STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

AMENDMENT # 1
RFP # 318.65-208

August 12, 2005

The subject RFP is hereby amended as follows.

A. The following RFP Schedule of Events updates or confirms scheduled RFP dates.

EVENT		TIME	DATE	UPDATED/ CONFIRMED
1.	State Issues RFP		July 15, 2005	CONFIRMED
2.	Disability Accommodation Request Deadline		July 22, 2005	CONFIRMED
3.	Pre-proposal Conference	1:00 p.m.	July 26, 2005	CONFIRMED
4.	Notice of Intent to Propose Deadline		July 29, 2005	CONFIRMED
5.	Written Comments Deadline		August 3, 2005	CONFIRMED
6.	State Responds to Written Comments		August 12, 2005	UPDATED
7.	Proposal Deadline	2:00 p.m.	August 22, 2005	CONFIRMED
8.	State Completes Technical Proposal Evaluations		August 29, 2005	CONFIRMED
9.	State Opens Cost Proposals & Calculates Scores	9:00 a.m.	August 30, 2005	CONFIRMED
10.	State Issues Evaluation Notice & Opens RFP Files for Public Inspection	9:00 a.m.	August 31, 2005	CONFIRMED
11.	Contract Signing		September 8, 2005	CONFIRMED
12.	Contract Signature Deadline		September 15, 2005	CONFIRMED
13.	Performance Bond Deadline		September 16, 2005	CONFIRMED
14.	Contract Start Date		October 1, 2005	CONFIRMED
15.	Readiness Review Begins (Administration and Management, Provider Network Review and Validation, QM Program, Member Services, Benefits, Fee Schedule, Prior Authorization, Information Systems, Encounter Interface, Claims Processing and Payment and other Program Components)		October 1, 2005	CONFIRMED

B. The following State responses to the questions detailed shall amend or clarify this RFP accordingly.

QUESTION/COMMENT	STATE RESPONSE
1. Please provide sample copies of the member handbook and the most recent member newsletter.	Each Managed Care Organization creates it's own "version" of a newsletter which is reviewed and approved by TennCare prior to distribution. Newsletters are generally a compilation of articles from various sources, may or may not have pictures, and range in level of sophistication. In the past, the DBM has coordinated with each MCO to provide an article for inclusion in *their* newsletter. Decisions regarding shared expenses are between the MCO and the DBM. TennCare is creating a Member Handbook template in order to standardize the information each organization provides to its members. It is anticipated that the template will be available sometime in the Fall. For your information, a dated TennCare Dental Plan Member Handbook is attached (Attachment 1) to this amendment, but we are unable to attach a sample newsletter as they are all in PDF format.
2. Attachment II, IV.E. states that all documents must be available in Spanish. Are Spanish documents sent to enrollees upon request, or are all documents to be printed in English and Spanish and automatically mailed to all members?	All vital documents must be printed in both English AND Spanish for mailing to enrollees. Documents are always supplied on request.
3. Attachment II, I.C requires provider directories to be sent to new enrollees. Are there any other requirement to mail provider directories to enrollees other than upon initial enrollment in the plan?	This requirement has been clarified by changes to ProForma Contract Section A.6.5 and ProForma Contract Attachment II (I C) to read "The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis." This language conforms to the requirement for the managed care contractors. Refer to Section C of this amendment, Items 2 & 4.
4. A.19.1 states that record layouts for required reports are available at the TennCare Informations Systems Library. Please provide these record layouts or instructions on where to retrieve these record layouts.	TennCare required the 837D HIPAA standard transaction set to be used for encounter reporting and the 834 to be used for enrollment. Both transactions related proprietary formats. All TennCare formats are available on the web at http://www.tennessee.gov/tenncare/HIPAA/HIPAA%20Home.html
5. Please provide more information on which dental services require prior approval and which dental services (or visits) require a referral.	Currently, the following kinds of procedures require authorization: Orthodontics, Crown (porcelain/ ceramic substrate), Crown (porcelain fused to metal), Core buildup, post (cast or prefabricated) and core, root canals (anterior and posterior), apexification /recalcification, apicoectomy /periradicular surgery, retrograde filling, gingivectomy or gingivoplasty, periodontal scaling and root planning, complete denture (maxillary or mandibular), Partial denture (maxillary or mandibular), extraction of impacted tooth, surgical removal of residual tooth roots, tooth reimplantation and or stabilization of accidentally evulsed or displaced tooth, surgical access of an unerupted tooth, biopsy of

	oral tissue, alveoloplasty-not in conjunction with extractions, removal of benign odontogenic cyst or tumor, removal of lateral exostosis, incision and drainage of abscess, frenulectomy, deep sedation, / general anesthesia, intravenous conscious sedation/ analgesia. In accordance with the ProForma contract A.7.6. Referral Requirements. **A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g. oral surgeon, endodontist, orthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals.**
6. Section A.3.2.b 11. requires a 24 hour telephone line accessible to enrollees. Can this be an automated information line with a paging service for emergency situations?	Yes.
7. Section A.13.3 requires the DBM to send a written remittance advice to providers. Is there any requirement to send a claim payment notice to the enrollee?	No.
8. Please define the "service site" mentioned in section A.17.1.e.	A service site is the location where the service is provided. This could be a dental office, dental clinic, outpatient hospital facility, etc.
9. Please provide the number of claims paid during the most recent (or available) 12 months.	The number of paid claims from July 1, 2004 through June 30, 2005 was approximately 713,928.
10. Please provide the average number of enrollees over the most recent (or available) 12 months.	615,924 child enrollees under age 21. 708,135 adult enrollees age 21 and older **THIS RFP IS FOR CHILDREN ONLY**
11. Is the Peer Review Committee established by the DBM or by TennCare? Are the members paid?	The Tennessee Peer Review Committee is established by the DBM within the parameters described in Pro Forma Contract Section A.18.3. There is no prohibition against paying members an honorarium or reimbursing travel expenses. This is a decision to be made between the contractor and the committee members.
12. If a new DBM is selected by TennCare, how long will the new DBM have to complete the credentialing of the contracted provider network?	The contract signing date is September 1, 2005 and the contract start date is October 1, 2005. Between October and December, TennCare and the contractor will work to prepare for the January 1, 2006 implementation date. The contractor must have its provider contract and credentialing documents reviewed and approved by TennCare and the Department of Commerce and Insurance prior to recruitment of any providers. After approval, the contractor should begin contracting with providers as quickly as possible because at the time of the Readiness Review – which will probably occur at the beginning of December, - the contractor's network MUST meet waiver access standards. The contractor will continue to contract for providers during the entire term of the contract, but implementation will **not** take place on Janaury 1, 2006 **if** the Readiness Review does **not** approve the

	network.
13. Section A.9.1.a. requires statewide provider training sessions. Are there any provider attendance requirements?	No, however the contractor is responsible for providers in its network being familiar with services requiring prior authorization, covered and non covered services, copayment requirements, appeals processes, etc. The statewide group sessions may preclude frequent visits to each provider office.
14. Of the 634,000 currently on the dental plan, how many (if any) are expected to disenroll due to recent TennCare cuts?	None. The most recent TennCare changes do not affect children in either program (TennCare Medicaid or TennCare Standard). Beyond the normal fluctuations of any Medicaid program, the number of enrollees is, at this time, expected to remain stable.
15. The current RFP Schedule of events only allows five working days from the time the State responds to written comments (August 15) to the proposal deadline (August 22). Given the critical nature of the State responses and additional information requested such as claims data, more time is needed to submit a quality proposal. Can the schedule be revised to include at least 10 working days between the State responses and the proposal deadline?	In an effort to provide more adequate timeline for preparation of proposals, TennCare is altering the RFP Schedule of Events to respond to questions prior to August 15th date, thereby allowing more time for proposal preparation after response to questions. Refer to Section A of this amendment, RFP Schedule of Events.
16. Please clarify what procedure codes are to be covered and administered. Section A.1.2 describes the Preventive, diagnostic and treatment services as well as Orthodontics. Are other services covered - such as fillings and root canals? Attachment VI, Provider Reimbursement Fee Schedule shows a number of codes to contract for. The leading paragraph seems to have contradicting language if these are the allowed codes or not. Please explain what is covered.	Early and periodic screening, diagnostic and treatment services (EPSDT) defined in section 1905(r) of the Social Security Act, enables Medicaid eligible children, under age 21, to receive dental care determined to be medically necessary, as well as children of the same age covered under TennCare Standard. The dental fee schedule (Attachment VI of the ProForma Contract) lists some of the more frequently performed dental services and is not meant to be exhaustive. All possible CDT 2005 codes have maximum allowable fees that have been established by TennCare. They will be made available to the contractor to be loaded in the claims processing system but are not necessary for inclusion in a fee schedule to secure a provider contract.
17. Please provide the last 24 months of detailed claims data. Preferably this would include data that shows number of claims paid by procedure code. If data is shown monthly please include monthly covered lives as well. We need this data to accurately determine the number and $ amount of claims processed per enrollee on a monthly basis.	The number of claims paid from July 1, 2003 through June 30, 2005 (24 months by state fiscal year) was 1,352,405. Most dental claims submitted include multiple services with different CDT procedure codes therefore; it is impossible to sort dental claims by procedure code or procedure code groupings. However, it is possible to provide the approximate number of dental services paid for last fiscal year by procedure code grouping. The total number of services paid from July 1, 2003 through June 30, 2005 was 4,167,104. Broken down by code grouping over the same time frame yields the following: 1,297,018 diagnostic dental services, 1,292,126 preventive dental services, 865,849 restorative services, 115,387 endodontic services, 2,227 periodontic services, 1,757 removable prosthodontic services, 60 implant services, 278 fixed prosthodontic services, 243,683 oral surgery services, 185,354 orthodontic services, 163,364 adjunctive general services.

18.	Please provide current and past administrative fees paid to the current vendor.	FY 2003 $5,067,300 (First payment was in October 2002) FY 2004 $6,341,800 Entire year Fy 2005 $6,393,100 Entire year
19.	Please provide performance guarantee and other penalty amounts paid by current contractor since inception in 2003.	A two million dollar ($2,000,000) surety bond remains in place. No liquidated damages have been assessed during the term of the contract.
20.	Please provide a listing of the current contractors dental network.	The "Current Dental Network," a spreadsheet of current contractors is attached (Attachment 2, of this amendment). This is an alphabetical list as reported by current DBM on 7/15/05. Names may appear multiple times representing multiple locations.
21.	Are all mailing expenses to covered enrollees homes to be covered by the Contractor?	Yes.
22.	Please summarize the reporting requirements of the Contractor. Please provide examples of what the current Contractor is providing and the frequency.	The reporting requirements and frequency are defined in the ProForma Contract Section A.19. The reporting requirements and frequency are defined in detail in the body of the contract. The following reports are examples of what the current contractor provides: Claims Activity Report-monthly, Batch Claims Operations Report-monthly, Encounter Data Report-monthly, Claims Lag Triangle-monthly, Provider Data Report-monthly, Appointment Assistance Report-monthly, Response Times Report-monthly, Utilization Review Committee Meeting Minutes-quarterly, Quality Assurance Committee Meeting Minutes-quarterly, Peer Review Committee Meeting Minutes-quarterly, Income Statements-quarterly, Enrollee Cost Share Reporting-quarterly, Employee, Enrollee and Subcontractor discrimination report-quarterly, Requests for Translation and Interpretation Services-quarterly, Satisfaction Surveys-Annually, Provider Race and Ethnicity Survey-Annually, DBM's policy demonstrating nondiscrimination in provision of services to persons with limited English proficiency-Annually.
23.	Is it necessary for the Contractor to have all claims processing, member services and preauthorization personnel located in the local Tennessee office?	No, however, per ProForma Contract Section A.3., it IS necessary for the contractor to have an office in the metropolitan Davidson County area and sufficient staff to be responsive to contracted providers, conduct site visits, attend meetings, provide outreach, participate in committees and otherwise fulfill the terms of the contract. Claims processing, member services and other large operations may be conducted from out of state as long as those operations are conducted satisfactorily and do not impede the Tennessee operation.
24.	Is the Go-DBE just interested in contracts within the state of Tennessee with small, minority and women-owned businesses? What about contracts outside of Tennessee?	Proposer's response to RFP Attachment 6.3, Question B.14 should include all small, minority and women-owned businesses, whether in State of Tennessee or not. TennCare is aware that many proposers of RFPs are located outside of Tennessee, therefore, in all likelihood would have no contracts with businesses within Tennessee.

25.	How should benefits be paid when an enrollee seeks services out of network? Can the contractor pay the dentist the lesser of billed charges or the contracted in network fee schedule? Can the dentist then bill the enrolled for any balance owed?	This question is addressed in ProForma Contract Section A.4.5. The contractor can pay the out of network provider no MORE than the fee schedule rate. The dentist CANNOT balance bill the enrollee for the provision of a covered service as provided by law.
26.	Can you please provide monthly claim volumes, not just the number of procedures, and monthly call volumes (categorically, if possible) for the past 36 months?	The monthly paid dental claims volume averages 56,350. The monthly submitted dental claims average 65,829. According to most recent reports, the call volume averages about 10-12,000 calls per month. TennCare does not require a report which breaks down calls by type although it is known that the current contractor IS able to track that information thru its member service module.
27.	Regarding A.4.2. Transport Time, what are TennCare's transport time standards for rural areas? What specific areas are affected?	Per A.4.2. of the ProForma Contract, the transport times are "usual and customary" – meaning that if it normally takes any individual an hour to get to a dentist because of the physical location of the only dentist, then that is "usual and customary". These specific areas are totally determined by the number of dentists contracted within any given area.
28.	Regarding A.5, Provider Network Requirements, how many providers are currently participating with the TennCare Network (number of dentists vs. number of offices/locations) and what is the annual provider turnover rate?	Approximately 756 providers are currently participating with the TennCare Network. More providers request to participate than request to end their participation. It is estimated that less than 1% of contracted providers left the network in 2004.
29.	Does TennCare set the required reimbursement for the FQHCs and if so, what is the "cost related basis"? If not, does this refer to reimbursing FQHCs on a fee-for-service basis similar to the reimbursement of all other dental providers?	The current DBM reimburses individual providers, county health departments, community health center providers and FQHCs according to the maximum allowable dental fee schedule.
30.	Please confirm that hard copy quarterly updated provider directories do not need to be sent to existing members unless they request a copy (A.6.5).	Refer to State's Response to Question #3.
31.	A.8.2, Transition Management. Please define "inquiries".	Any contact made to the current DBM regarding needed dental services should be referred to new contractor for services.
32.	Attachment 6.4, Cost Proposal and Scoring Guide. What consideration, if any, will be given to removing start-up/implementation costs from the cost comparison for scoring purposes? Is TennCare willing to factor this into the scoring of cost proposals?	The only thing considered in cost comparison is per member per month rate submitted in cost proposal. Of course the vendor' s Start up/implementation costs must be factored into the per member per month rate. There will not be a separate payment from TennCare for start-up/implementation costs, the PMPM fee must include all contractor expenses.
33.	Is it acceptable for the technical proposal to include one binder with the narrative technical proposal and the applicable exhibits in an accompanying binder?	Yes.
34.	"Provide customer references for similar projects representing both three of the larger accounts currently serviced by the vendor and three completed projects as well as a list, if any, of all	"Completed" projects are those for which the Contractor is no longer providing services of any kind.

	current contracts with the State of Tennessee and all of those completed within the previous five year period. Please define "completed" projects?	
35.	Will TennCare make public the identity of those vendors that have submitted a Notice of Intent to Propose? If yes, which organizations have submitted a Notice of Intent to Propose?	Department of Finance and Administration Policy .03a 10 PUBLIC INSPECTION OF RFP FILE states: " When it issues the RFP Evaluation Notice, the procuring agency must also open the RFP file including all proposals and associated materials for review by the public in accordance with applicable law and any applicable agency rules, policy, and procedure.When the RFP file is opened for public review, it MUST detail the exact dollar amount of the protest bond that is required should a proposer wish to protest the RFP process. The amount must be determined in accordance with **Tennessee Code Annotated, § 12-4-109(a)(1)(E)(iii)**. " Per Schedule of Events on Page 1 of this amendment, RFP files will be open for Public Inspection on August 31, 2005.
36.	Attachment VI on page 104 lists the ADA codes and their provider fee for basic services, are there any other ADA codes and provider fees utilized by TennCare that are not on this list?	Refer to State's Response to Question #16.
37.	Has TennCare established standard medical necessity or emergent ADA codes that guide the Contractor in their medical discussions with the MCO in question?	No. TennCare hasn't established ADA codes that guide Contractor. The MCO/Contractor interaction revolves around the services that take place in an out-patient facility, not a particular code.
38.	For comparison purposes, we request TennCare provide a current listing of the approved dental network providers inclusive of their address .	Refer to Attachment 2 of this amendment.
39.	We request TennCare provide the amount paid and number of dental claims approved and paid by year based on the life of the incumbents recent contract including the extension of said contract.	FY 03 (started in Oct) $75,905,300 FY 04 $126,001,600 FY 05 $ 125,364,600 Claims volume and detailed service data are provided in State's Response to questions #9, #17, and #26 of this amendment.
40.	What annual percent of these claim payments require prior approval? What annual percent of these claims require medical discussions/resolutions with the enrollees MCO?	Approximately 12% of the dental claims submitted from July 1, 2003 through June 30, 2005 were related to authorization requests. Part 2 of the question is not a statistic that TennCare has available.
41.	We request a listing of the dental providers that are restricted or eliminated from providing services to TennCare enrollees?	There is no list of dental providers that have been restricted or eliminated from providing services to TennCare enrollees. Dental providers must complete credentialing before contracting. The credentialing requirements are fully outlined at ProForma Contract Attachment IV, Standard IX. If a provider fails to meet these requirements then you need not offer a contract. There is no "entitlement" to participate.
42.	Who is responsible for correcting enrollees address information?	TennCare. It is always the intention of the state to provide accurate and up to date information on members however the

		accuracy of our information is totally dependent on the self reporting of the member when addresses/phone numbers change.
43.	Is the Contractor require to bear the postal cost for all required TennCare mail outs i.e. Member Handbook, Quarterly Newsletter and other items as outlined in Attachment II?	Yes.
44.	For the purposes of compliance with E-PHI what type of encryption program does TennCare have in place?	TennCare does not use an encryption program. Data is exchanged via secured network connection.
45.	Specific to 1.9 Performance Bond on page 6, can TennCare provide a written criteria that defines the term "form and substance acceptable to the State"?	The form and substance accepted by the State is a bond issued by a surety company licensed to transact business in the State of Tennessee by the Tennessee Department of Commerce and Insurance. Bonds shall be certified and the current power of attorney for the surety company's attorney-in-fact must be attached. RFP Attachment 6.6 must be completed and included as part of the vendor's proposal.
46.	Section 4.14 page 14 implies in part that the proposals and attachments can be viewed by the public, will TennCare de-identify any data where applicable prior to publication to avoid potential identify theft of the company and/or individuals referenced in these proposals?	Department of Finance and Administration Policy .03a 10 PUBLIC INSPECTION OF RFP FILE states: " When it issues the RFP Evaluation Notice, the procuring agency must also open the RFP file including all proposals and associated materials for review by the public in accordance with applicable law and any applicable agency rules, policy, and procedure.When the RFP file is opened for public review, it MUST detail the exact dollar amount of the protest bond that is required should a proposer wish to protest the RFP process. The amount must be determined in accordance with **Tennessee Code Annotated, § 12-4-109(a)(1)(E)(iii)**." Section 4.14 of RFP states "Upon the completion of the evaluation of proposals , indicated by public release of an Evaluation Notice, the proposals and associated materials shall be open for review by the public in accordance with Tennessee Code Annotated, Section 10-7-504(a)(7**). By submitting a proposal, the Proposer acknowledges and accepts that the full proposal contents and associated documents shall become open to public inspection."**
47.	Will TennCare provide proper markers in their electronic eligibility download which identify enrollees who have no cost sharing vs. those who do have cost sharing responsibilities under this dental program?	Yes. That information is part of the eligibility record supplied for each member by TennCare. The copay amount(s) is also listed on the member's MCO ID Card so that a provider should be aware of the copay requirement and amount.
48.	Will TennCare honor in network dental provider's assignments?	Currently, the DBM does not assign patients to dental providers. The enrollee has the freedom to choose among the contracted providers.
49.	After reading section A.22.1 a. Dental Services Payments and then reading Section A.23 Financial Requirements page 49, we request TennCare provide a description of circumstances	Operating as a risk bearing entity would be a decision made by TennCare and negotiated with the contractor. At this time, it is not anticipated that this contract will become a risk bearing

	that may/must be present which would require the Contractor to operate as a risk-bearing entity for dental services.	contract.
50.	Specific to the Provider correction action plan, can TennCare share with us the current criteria in place that defines in-appropriate care by the provider?	"Inappropriate" care generally means not conforming to accepted standards of dental and oral health practice. The contractor's utilization review process must have intervention mechanisms in place that safeguard children, improve quality of care, assure fiscal viability of the program and comport with TennCare's mission. These options will include issuance of corrective action plans, provider education, recoupment of provider payments or any combination of these actions. Additionally, in accordance with the conditions of its Provider Service Agreement, the contractor may also choose to exercise its prerogative to terminate a dental provider.
51.	Specific to the Provider correction action plan, can TennCare share with us the current criteria in place that defines in-appropriate care by the provider?	Refer to State's Response to question #50.
52.	How will the contractor be informed of the percent of poverty the member qualifies under to ascertain the member's co-pay and out of pocket expenses? (A.1.3)	That information is part of the eligibility record supplied for each member by TennCare. The copay amount(s) is also listed on the member's MCO ID Card so that a provider should be aware of the copay requirement and amount.
53.	How will the State inform the contractor of the members who have reached their out of pocket maximum and are eligible for reimbursement? (A.1.3)	The out of pocket maximum requirement has been eliminated by recent changes in the waiver. However, there is still a requirement for the contractor to provide copay information to TennCare until it is determined that sufficient run out information has been obtained. A copy of co-pay file layout is attached (see Attachment 3 of this amendment). The contract has been amended to exclude references to out of pocket maximums.
54.	Should there be an item #4? Item #3 ends with "...;or" (A.1.3).	Yes. The contract has been amended to read "or...4. the enrollee requests services that are non-TennCare covered services provided at the option of the CONTRACTOR in accordance with the terms of this Contract." Refer to Section C, Item #1, of this amendment.
55.	How may we obtain copies of TennCare's written policies and procedures? (A.1.4)	TennCare policies and procedures are generally covered in Rule (1200-13-13 and 1200-13-14) and information contained in our waiver document. All of that information is available at www.Tennessee.gov/TennCare under Providers and then Guidelines.
56.	Would the contractor's Dental director qualify for this request? If not, what kind of medical training is the State expecting, i.e. registered nurses, dental personnel? (A.3.2.b. #5)	The contractor's Dental Director would qualify plus any staff the contractor deemed – and TennCare agreed – had sufficient medical/dental experience to qualify them to make evaluative decisions.
57.	How will the State notify the contractor of special needs enrollees? (A.7.6.)	Since the Contractor is in direct contact with the enrollee when providing service, they are expected to respond accordingly to any special needs detected, and that the State system does not include notations on special needs of enrollees.
58.	Are the referrals referenced in the "tracking system" the referrals managed by the contractor within its network of providers; or are these the	The referrals referenced in the "tracking system" are the referrals managed by the contractor within its network of providers.

	"referrals" to the dentist issued by a primary care provider within the MCO's network; or is it referring to the requests from a member for assistance to obtain an appointment as mentioned in A.19.2 Referral Time report? (A.8.4.)	
59.	Please describe the process followed to notify the contractor of pregnant women and children in State custody who have temporary ID and eligibility. (A.20.1.c.)	The contractor will not be notified regarding pregnant women, however, once a child is born they are immediately eligible for medical as well as dental services. DCS is responsible for notifying TennCare within 24 hours of a child's being taken into State Custody via a daily custody file. This information is then passed on to the DBM via daily eligibility file.
60.	Under what circumstances and how would the State direct the contractor to operate as a risk bearing entity for dental services? Will the State seek an amendment to the contract as described in section D.2? (A.23.)	Refer to State's Response to Question #49.
61.	How were the benchmarks established by the State and when will the contractor be expected to meet the target measures? (A.24)	Some of the benchmarks were established by Court Order, some by Waiver Special Terms and Conditions and some by Statute. The contractor will be expected to meet the performance indicators from the start of the contract with the exception of ProForma Contract Section A.24.2 which will be measured annually.
62.	This section references the opportunity to cure breach "as described in section E.4.b, but there is no such language in any section of the contract. Will this language be added to the contract by the State? (E.4.b.iii)	ProForma Contract Section E.4 has been replaced in its entirety. Refer to Section C., Item #3 of this amendment.
63.	Please provide any available statistics on call volume from providers and members. If available, it would help to have a breakdown of the types of calls received from program providers and members (i.e. looking for a dentist, claims questions, benefits questions, etc.)	Please refer to State's Response to question #26.
64.	Please provide utilization rate per thousand members, or claims volume, or access penetration rate to assist with the preparation of claims processing requirements.	Refer to State's Response to Questions #9, #10, #17, #26 and #29.
65.	Please provide provider network information such as: number of participating dentists, number of general dentists, number of specialists, number of pediatric dentists, number of oral surgeons, number of orthodontists.	These numbers are approximate: General dentists – 521; Pedodontists – 62; Oral Surgeons – 89; Orthodontists – 74; Endodontists – 4; Periodontists – 3; Prosthodontists – 3.
66.	The RFP states that the program is for approximately 635,000 members. Can the State provide us with the number of "case heads" in the program?	No.
67.	In the Pro Forma Contract, the State specifies that the contractor is a corporation which has qualified as an Administrator (aka "Third Party Administrator") in compliance with Tennessee Code Annotated Section 56-	If the entity is licensed in the state of Tennesee as an insurance company or HMO, then a separate TPA license is not required.

	6-401. Will contractors with a State of Tennessee insurance license be exempt from the TPA license requirement?	
68.	Will the State provide a census with the date of birth, gender, zip code and coverage type?	The state will provide daily updates of all eligible members which will include that information. TennCare is unclear what is meant by "coverage type". All eligible children have the same benefit package.
69.	Will the State provide the current administrative service fee per member per month?	The previous contract paid $0.75 pmpm for children and $0.10 pmpm for adults. THIS RFP IS FOR CHILDREN ONLY.
70.	In regards to item A.7.6 Referral Requirements, the State specifies that a patient must be referred by a general dentist or pediatric dentist to a dental specialist for the initial visit for services requiring specialized expertise. Would the State consider making this an optional requirement? Enrolled participants could then seek services from any network provider.	No.
71.	In section A.19.1 Report Requirements, will the State provide the most recent monthly claim lag report and monthly claim activity report? Will any claims experience or utilization reporting be made available?	Re: claims lag – TCA 56-32-226(b)(1) requires that 90% of clean claims be paid within 30 days and 99.5% within 60 days. Re: utilization experience, Refer to State's Response to Questions #9, #10, #26, and #39.
72.	In regards to item A.4.5 Out of Network Providers, the State specifies that the out of network providers must coordinate with the Contractor with respect to payment and the contractor must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network. Will additional reimbursement be allowed by the State to cover out of network provider fees?	No.
73.	Will the State provide an example of the administrative services bill? Specifically, how is the current billed structured?	In accordance with ProForma Contract Section C.3. Payment Methodology the contractor shall be compensated based on a fixed fee per member per month as specified. Each monthly payment to the contractor shall be equal to the number of enrollees certified by TennCare multiplied by the administrative fee. No invoice is required.
74.	In Attachment II Evidence of Coverage and Enrollee Materials, would the State provide additional details about the current method used to distribute these items. For example, are bulk shipments sent to the various health departments? Or are these materials distributed by TennCare when the participant enrolls?	Evidence of Coverage and Enrollee Materials are mailed individually to the most current address provided for EACH enrollee. The contractor is solely responsible for the creation and distribution of these materials.

75.	Under section A.1.3 Enrollee Cost Share Responsibilities, will the State provide an example of the Contractor tracking report? Also, will the State clarify how the aggregate out of pocket maximum is administered by the dental benefits administrator?	Refer to State's Response to Question # 53.
76.	Under section A.1.3, Enrollee Cost Share Responsibilities, do the providers collect the co-pays at the time of the appointment? Please further describe this current process.	Yes. The payments they then receive for claims cost for enrollees with cost share responsibilities are "less" the cost share. The providers may not waive copays.
77.	In item B.2 Term Extension, please confirm that the State's definition of the maximum liability. Does this terminology refer to the premium rates negotiated for the extension period?	Yes.
78.	When referencing Technical Proposal and Evaluation Guide -Section C; C.1 which focuses on specifics outlined in Attachment 6.1 ProForma Contract, is it desired for the proposer to express their understanding of the State's requirements by identifying each section, then acknowledging the content in that section and providing attachments (Exhibits) that demonstrate ability or infrastructure to perform this task or requirement? For example: To answer C.1 and to demonstrate we understand the contract section A.18 Quality of Care requirements from A.18.1 -A.18.3; should we provide a narrative for each section and provide Exhibits, such as our Quality Management Plan, sample of minutes etc. Another Example: To demonstrate we understand and can meet reporting requirements do we need to restate items outlined in the contract document and include sufficient documentation to demonstrate reporting requirements can be met? Would this be the expectation to thoroughly answer C.1?	"The proposer must address ALL technical approach items and provide, in sequence, the information and documentation as required (referenced with the associated item references as stated in RFP Attachment 6.3 C)." Also refer to RFP section 3.2.6. which reads as follows: "The State may determine a proposal to be non-responsive and reject it if the Technical Proposal document fails to appropriately address/meet all of the requirements detailed in the Technical Proposal and Evaluation Guide."

C. Delete the following sections in their entirety and replace with the following:

1. A.1.3. Enrollee Cost Share Responsibilities. The Contractor and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations or TennCare approved policies and procedures for TennCare enrollees, nor may the Contractor and all providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's

insolvency. Enrollees may not be held liable for payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers.)

Cost sharing responsibilities shall apply to services other than the preventive services described in Section A.1.2.1 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The procedure code listing for preventive services is as follows:

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1201	Topical Application of Fluoride (Prophylaxis included) - child
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

The current sliding scale schedule to be used in determining applicable cost sharing responsibilities for TennCare enrollees is described in the chart below.

Co-Pay	0 to 100% of Poverty	101-199% of Poverty	200% and Above Poverty
Dental visits	0	$15 per visit	$25 per visit

The Contractor shall track and report to TennCare the amount of enrollee cost-sharing liabilities on a quarterly basis in a form and format to be specified by TennCare.

The Contractor shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required by TennCare. Further, the Contractor shall not discourage enrollees from paying applicable co-payment obligations.

If, and at such time that changes occur to the cost sharing rules, the contractor will be notified of new co-payment rates.

The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of cost sharing responsibilities due from the enrollee, once a Contractor becomes aware the Contractor shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the Contractor, if a provider continues to bill an enrollee, the Contractor shall refer the provider to the TBI.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services except as permitted by TennCare rule 1200-13-13-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

1. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider

bills the DBM for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

2. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills the DBM for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

3. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts must be refunded when a claim is submitted to the DBM if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or

4. the enrollee requests services that are non-TennCare covered services provided at the option of the Contractor in accordance with the terms of this Contract.

2. A.6.5. Provider Listing. The Contractor shall provide all enrollees (or heads of households), with a provider listing within thirty (30) days of initial enrollment, and upon request, such list shall include current provider address(es), telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. All provider directories shall be approved by TennCare prior to the Contractor's distribution.

3. E.4. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;
— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the state shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages— In the event of a Breach, the State may assess Liquidated Damages. The State shall notify the Contractor of amounts to be assessed as Liquidated Damages. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Liquidated Damages contained in above referenced, Attachment 1 and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Liquidated Damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the liquidated damage amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

The State may continue to withhold the Liquidated Damages or a portion thereof until the

Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the Contract. The State is not obligated to assess Liquidated Damages before availing itself of any other remedy. The State may choose to discontinue Liquidated Damages and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said Liquidated Damages previously withheld except in the event of a Partial Default.

(3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Liquidated Damages against the Contractor for any failure to perform which ultimately results in a Partial Default with said Liquidated Damages to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken

(4) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

4. Attachment II, I.C. Provider Directory.

Provider Directory. The Contractor shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan. The

Contractor shall also be responsible for redistribution of updated provider information on a regular basis and shall redistribute a complete and updated provider directory at least on an annual basis. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients. Enrollee provider directories, and any revisions thereto, shall be submitted to TennCare for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TennCare and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

The Contractor may choose to provide a modified provider listing to enrollees who are only eligible for the limited Dental Benefits as described in Section A.1.2.3 of this Agreement. However, all provider directories shall be approved by TennCare prior to the Contractor's distribution.

ATTACHMENT 1

TennCare[SM] Dental Plan

MEMBER HANDBOOK

What is TennCare[SM]?

TennCare[SM] is the health plan run by the state of Tennessee. This plan is for people in the TennCare[SM] Program. The rules of the program are there to help people stay healthy. The Bureau of TennCare[SM] makes the rules.

Who is Doral Dental?

Doral Dental works with the Bureau of TennCare[SM] to make sure the dental plan runs well. Doral will be working with you to make sure you can get the dental care you need. We can answer any questions that you have about your dental plan. Our phone number is 1-888-233-5935.

Assurance of Non-Discrimination

We do not allow unfair treatment in TennCare. No one is treated a different way because of race, color, birthplace, language, sex, religion, beliefs, age or disability. If you feel you have been treated unfairly because of this, please call 1-888-233-5935. Please see page XXXX for a copy of the discrimination complaint form.Table of Contents

Para personas que hablan Espanol: Para mas informacion llame al centro de informacion del Proyecto en espanol de TennCare al Tel.: **(615) 227-7568** si su llamada es en el condado de Davidson o condados que lo rodean, si es de larga distancia llame al Tel.: **1-800-254-7568.**

How to Use this Handbook

If you need interpretation/translation services, please call Doral at 1-888-233-5935. We can provide a translator for you over the phone. Interpretation and translation services are free.

This handbook will tell you all about your dental plan. It tells you what to do to schedule an appointment. It tells you what is covered by your dental plan. It gives you phone numbers that you will need to call to get more information. All of the things that you need to know about your dental program are in this handbook.

Enrollment

You do not need a TennCare[SM] dental card. The TennCare[SM] card you have will work for dental care. **TennCare[SM] will not pay for services received before the effective date on your ID card. Services received before the effective date on your ID card will not be covered by TennCare[SM].** The effective date on your ID card will tell you when you are starting the TennCare[SM] dental plan.

While you are eligible for the TennCare[SM] dental plan, you will receive newsletters and other items. Please read them. They will contain interesting facts that will help you take care of your teeth.

If your TennCare[SM] enrollment ends, you will be sent a letter saying that you are no longer covered by the TennCare[SM] health plan. This also means that you are no longer covered by Doral Dental. **The date stated by the letter will be the last day that you will be covered by TennCare[SM]. Any services that you get after the termination date on the letter will not be paid for by TennCare[SM]. You will have to pay for any services received after the termination date on the letter.**

The effective date on your ID card will tell you when you are starting the TennCare[SM] Program. You will use the same card and effective date for your dental services. You will not get a new card in the mail

Coverage

> Some services will need to be approved by Doral before you can get them. An approval that you got from a plan not in the TennCare [SM] program will not be valid.

TennCare[SM] will only cover services you need to stay healthy.

Members under 21 years old

TennCare[SM] members under 21 years old are covered for a lot of services under the TennCare[SM] program. Members can get all medically necessary services. Exams will be used to see if other services are needed. Some of the services that are available to you include:

- ✓ Fluoride Treatments
- ✓ Some Sealants
- ✓ Cleanings
- ✓ Space maintainers

- ✓ X-rays
- ✓ Fillings
- ✓ Crowns (some caps)
- ✓ Braces (if qualified)
- ✓ Root Canal Treatments
- ✓ Extractions (tooth pulling)
- ✓ Anesthesia
- ✓ Oral Disease Services

Your dentist will tell you if a service is going to be paid by TennCare[SM] or not before they treat you.

Preventive Services

NO ONE HAS TO PAY A COPAYMENT FOR COVERED PREVENTIVE SERVICES.

Preventive services can be seen in this table for members under the age of 21:

Tooth cleaning for members under 21 years old
Fluoride treatment for members under 21 years old
Nutritional Counseling for Control of Dental Disease
Tobacco Counseling for the Control and Prevention of Oral Disease
Tooth Care Instructions
Sealant per Tooth

Under EPSDT (Early Periodic Screening, Diagnosis and Treatment) for children under 21 TennCare[SM] covers:

> Regular, periodic visits to the doctor to see if the child is developing normally and to see if he or she has any physical or mental problems. This is called "screening" and needs to happen according to a regular schedule. **For example, children from birth through age 2 are entitled to 11 "screens"; from age 3 through 11- 7 "screens" and from age 12 through 20- 9 "screens**". In addition, a child is entitled to a "screening" whenever the child is referred to a doctor by someone such as a teacher who notices a change which might require a "screening"; and treatment, including rehabilitation, for any health problems (physical, mental or developmental) discovered during a "screening"; and regular visits to a dentist for checkups and treatment; and immunizations (shots) for diphtheria, tetanus, pertussis, polio, measles, mumps and HIB flu: and lab tests for lead in blood and sickle cell anemia if the child is in a situation that might put him or her at risk for either or both.

Members 21 years old and over

TennCare[SM] does not pay for dental services for members 21 years and older **except** for services needed as a result of the following:

- Accidental injury* to mouth and natural teeth
- Certain harmful growths in the mouth
- Life threatening infection**
- Removal of impacted wisdom teeth

* *Accidental injury must be caused by an external force such as a car accident or another unnatural occurrence. The accident must have happened within 12 months of your dental appointment. You need to have been on TennCare[SM] at the time of your accident. Prior authorization will be given to members with medical necessity.*

** *Prior authorization will be given to your dentist if there is medical necessity. You must have a letter from your Medical Doctor before you go to the dentist. This letter must tell your dentist why an infection in your mouth will be life threatening. Some examples of an illness that would be considered life threatening would be people with or scheduled to receive a prosthetic heart valve, organ donor, or individuals with compromised immune systems.*

If you need dental services due to one of these conditions, please contact Doral Dental. Our phone number is 1-888-233-5935. We will find you a dentist who will do an exam and x-rays. The dentist will let you know what steps you need to take to fix the problem. The dentist will be able to tell you if the services that you need are covered.

Finding a Dentist

Doral Dental will help you find a dentist or dental specialist. There are many dentists that are available to treat you.

For information on which dentists or dental specialists you can go to please contact Doral Dental. If you do not like the dentist you are seeing, please call us and we will help you find a new dentist. Our phone number is 1-888-233-5935.We can help you find the closest dentist that is in the program. Only dentists and dental specialists that are in the TennCare[SM] program can treat you for non-emergency services. The names of all dentists and dental specialists in the TennCare[SM] program are available to you in a provider directory and by calling Doral Dental at 1-888-233-5935.

When you call Doral Dental, you should have these items ready:

- Pen or Pencil
- Your ID Card or Social Security Number

When you call Doral Dental, tell them that you are a TennCare[SM] member. Let Doral Dental know why you want to go to the dentist. Doral Dental can give you the names of some dentists in your area. You will receive the names of several dentists in your area. **You do not have to get a referral**

from your medical doctor (PCP) to go to a dentist. <u>You will need a verbal referral from a general dentist or pediatric dentist to go to a dental specialist.</u>

<u>Making an Appointment</u>

When you call the dentist, you should have these items ready:

- Pen or pencil
- Your ID Card
- Your calendar

When you call the dentist's office, tell them that you are a TennCare[SM] member. Let them know that you would like to make an appointment to see the dentist. See which dates and times work best for you. When the date of your appointment comes, just go to the dentist's office. It is that easy. If you have been going to a different dentist, please ask the old dentist to send your dental records to your new dentist.

<u>At the Dentist's Office</u>

When you go to the dentist's office, you should bring your ID Card.

When you go to the dentist's office, just show the receptionist your ID card. The dentist will see you shortly. The dentist can give you some helpful tips on taking care of your oral health.

<u>Emergency Services</u>

Your child can also see a Doral dentist for emergencies. You should ask your dentist how to contact him or her in an emergency. Your dentist may have a different telephone number to call in an emergency. **If you have an emergency, you can call Doral any time of the day or night. We always have someone here who can help you get emergency treatment. Please call us at: 1-888-233-5935.**

<u>Out of Plan Dentists</u>

If you are away from home during an emergency, take your child to any dentist in the area. If you cannot find a dentist, take your child to the hospital if necessary. Remember to show your Member ID Card.

<u>Know Your Rights</u>

As a member of the TennCare[SM] program, you have rights. You have the right to:

- ✓ Be treated with respect, dignity, and privacy
- ✓ Know about Doral Dental, TennCare[SM], and your dentist
- ✓ Be able to choose a dental care giver from the TennCare[SM] directory
- ✓ Be able to refuse care from a specific dentist
- ✓ Receive information about TennCare[SM] and the services available to you
- ✓ Make decisions about your dental care
- ✓ File a complaint or appeal about Doral Dental, a dental care giver, or TennCare[SM]
- ✓ Have access to your dental records

- ✓ Submit a written request to Doral to change or update your dental records. Doral may not agree to your written request.
- ✓ Not be discriminated against by the health care provider on the basis of age, sex, race, physical or mental handicap, national origin, ethnicity, religion, sexual orientation, genetic information, source of payment or type, or degree of illness or condition.
- ✓ Leave the TennCare[SM] program even if you qualify for benefits. You can do this by calling TennCare[SM] at 1-800-669-1851 and asking for a disenrollment form.
- ✓ Have Doral keep your health information private pursuant to state and federal laws.
- ✓ Be told of changes in services or if your dentist leaves TennCare[SM].

Your Responsibilities

As a member of the TennCare[SM] program, there are some things that you need to do. You are responsible for:

- ✓ Using the TennCare[SM] dental program
- ✓ Knowing, understanding, and following the terms and conditions of this handbook
- ✓ Listening to the dentist
- ✓ Taking care of your teeth
- ✓ Making appointments
- ✓ Keeping appointments
- ✓ Paying your copayments and premiums
- ✓ Making sure you are the only person who uses your TennCare[SM] identification card and letting TennCare[SM] know if it is lost or stolen.
- ✓ Showing your TennCare[SM] ID card and any other insurance card when you go to the dentist.
- ✓ Answering questions about your health that will help your dentist take care of you.
- ✓ Canceling appointments and scheduled transportation as early as possible
- ✓ Letting your doctor know if you have had care in an emergency room within 24 hours
- ✓ Immediately informing TennCare[SM] of any of these things:

1. An address change each and every time you move
2. A phone number change each and every time you change phone numbers
3. If you have a new baby or have a family size change
4. If you (or an immediate family member) lose your job, become employed or have other insurance
5. A name change

Please send this information (including your social security number) to:

TennCare[SM] Member Services
PO Box 22630
Nashville, TN 37202-2630

If you live in Davidson County you can call 741-4800.
If you live outside of Davidson County you can call 1-800-669-1851.

New Law Passed

The Tennessee General Assembly has passed a new law. This law (T.C.A. § 71-5-118) makes it a criminal act if anyone deliberately obtains TennCare coverage based on false facts. It is also against the law:

- For another person to help anyone obtain TennCare[SM] coverage based on false facts
- To misrepresent, impersonate, or to conceal any fact that would cause TennCare[SM] to provide coverage when a person is not otherwise eligible
- To get or help someone get additional benefits or benefits at a higher level than for which they are entitled to receive
- For any individual or business to make a false statement about a person's health status or eligibility for health insurance

Appeal Rights and Hearing Rights

If you feel that something in the TennCare[SM] program has happened that has denied, reduced, ended, delayed, or stalled a covered service you can file an appeal. If you feel that Doral Dental has hurt the quality, timeliness or availability of your TennCare[SM] benefits, you can file an appeal. You can request TennCare reassess your eligibility status if you feel it is incorrect. To file an appeal:

1. Call TennCare[SM] Solutions Unit at 1-800-878-3192. Tell them that you want to file an appeal. They will take your appeal over the phone, or
2. Send an appeal form to:

TSU
P.O. Box 000593
Nashville, TN 37202-0593

You can get appeal forms by calling TennCare[SM] or Doral Dental and asking for one. You can also get an appeal form from any TennCare[SM] dentist's office.

If you would like to file an appeal to TennCare[SM] about an enrollment decision, or any other decision made by TennCare[SM] please call TennCare[SM] at 1-800-669-1851.

The TennCare Solutions Unit (TSU) can help you get the health care you think you need. It can also answer your questions about your appeal rights. They can help you start an appeal. You can call them at **1-800-878-3192**, or you can write the TSU at P.O. Box 000593, Nashville, TN 37202-0593. Please call during the day if possible, but you may call anytime. If you have an emergency, someone can help you day or night.

If you need special help with an appeal because you have a health, learning, or other problem, please let us know. When you call the TSU at **1-800-878-3192** tell them about any help you need.

Do you have a speech or hearing problem and use a **TTY machine** to talk on the phone? There are operators to help you. A **TTY machine** will answer your phone call if you call **1-800-772-7647** or **313-9240** in the Nashville area. These telephone numbers are to be used **only** by those with a **TTY machine.**

YOUR APPEAL RIGHTS

1. You have the right to appeal if you cannot get the health care you need when you need it. You can appeal even **if you do not have a doctor** to prescribe what you need. An appeal can help you get the care you need. You have 30 days to appeal. The 30 days start when you find out there is a problem.

2. If you appeal, someone else will take a look at what you need. They will try to fix it quickly. If they cannot, you will get a chance to tell your side of the story to someone who does not work for TennCare[SM].

3. You have the right to get a letter from us if we (1) do not give you care, or (2) stop or cut your care, or (3) make you wait too long for medical care. The letter must say why we decided this and what you can do about it.

4. You have the right to get an answer when you need it. You need your TennCare[SM] health plan's OK ahead of time for certain types of care. If we take longer than 21 days to decide, we MUST give you the care you asked for. You can appeal before the end of the 21 days if the care you need cannot wait that long. Be sure to ask for a fast appeal.

5. You can get a fast appeal in some cases. You or your doctor must think the care is needed right away. Tell TennCare[SM] why you need a fast appeal.

6. If you are already getting care, you may be able to keep getting it during the appeal. To do this, you must appeal by the date your care will be cut or stopped (usually 2 or 10 days). You must say that you want to keep getting the care during the appeal. **If you must have a doctor's order or prescription for the care, you can only keep getting the care if you have a doctor's order or prescription.** If the appeal is decided against you, you might have to repay TennCare[SM] for the cost of the care you got during your appeal.

7. In most cases, you have a right to get medicine even if the drug store says TennCare[SM] does not cover this drug. You may get a different drug that your doctor has OK'd. If not, you will get some of the drug your doctor ordered. **NOTE: You will not get the medicine if:**

   It would not be safe for you, OR
   It is a drug that does not work, OR
   It is a drug that is part of a group of drugs that TennCare[SM] does not cover for adults.

8. You may have the right to be told before we cut the care you are getting. If we decide to cut your care, you have the right to be warned in writing 10 days before it happens. If your DOCTOR wants to cut your medical care, you have the right to a two-day warning IF:

   (a) You are getting inpatient psychiatric or residential services; OR
   (b) Your TennCare[SM] health plan cannot get the care right away that you need next for your long-term health problem; OR
   (c) You are getting home health services.

If we do not tell you in time, we CANNOT cut your care.

9. You have the right to have TennCare[SM] pay your medical bills. Are you getting bills that TennCare[SM] should pay for? You must appeal within 30 days after you get the bill.

Your TennCare[SM] Hearing Rights

You have a right to:

1. Have a hearing if your problem is not fixed
2. Know about the hearing 3 weeks ahead of time (1 week for fast appeals)
3. Be at the hearing in person or by phone
4. Speak for yourself at the hearing
5. Have someone help you at the hearing
6. See the information TennCare[SM] and your health plan used to decide about your care. You can see this before the hearing
7. Look at your medical records and use them as proof
8. Give the judge proof about your health and medical care
9. Bring witnesses to testify for you
10. Have the judge order your witnesses to come
11. Question witnesses for TennCare[SM]
12. Show proof that the health plan made the wrong decision
13. Ask to have a doctor who does not work for TennCare[SM] say what medical care you need. You do not have to pay for this
14. Get a written decision in 90 days (31 days if it was a fast appeal). If the decision is late, you can get medical care until the decision is made. This is NOT true if you are the reason the decision is late

<u>Important Rights If You Have a Health Problem</u>

Are you getting health insurance after TennCare[SM]? Because you had TennCare[SM], the law gives you certain rights when you apply for other insurance. To get these rights, you have to prove that you had TennCare[SM]. To prove that you had TennCare[SM], you need a "Certificate of Group Health Plan Coverage".

We will give you this Certificate if you ask. A replacement certificate is available if you need one. Call the TennCare[SM] Information Line at 1-800-669-1851. This is a free call. In Nashville, call 741-4800.

<u>Voluntarily Leaving the TennCare[SM] Program</u>

You can leave the TennCare[SM] program at any time. If you would like to leave the program, and end your TennCare[SM] benefits, please call TennCare[SM] at 1-800- 669-1851. TennCare[SM] will tell Doral to end your benefits after they have talked to you.

Taking away your TennCare[SM] Benefits

Here are some of the reasons TennCare[SM] could take away your benefits:

- ✓ You no longer qualify for TennCare[SM] eligibility
- ✓ You are able to pay for co-payments, but do not do so
- ✓ You move out of the service area
- ✓ You are found to have abused your TennCare[SM] services by letting someone else use your TennCare[SM] ID card

- ✓ You obtain TennCare[SM] eligibility by: fraud, misrepresentation, deception or eligibility can not be verified
- ✓ The Bureau of TennCare[SM] cannot locate you
- ✓ Death

Changing Your Address, Name or Other Information

When you move or change your name, you need to let TennCare[SM] know right away. Send any of these changes to:

The Bureau of TennCare[SM]
P.O. Box 22630
Nashville, TN 37202-2630

First tell TennCare[SM] what your current name, address and phone number are. Then tell them what information you want to change.

Questions About Your Dental Program?

Doral Dental or TennCare[SM] can answer any questions that you have about your dental plan. If you would like to ask Doral Dental a question, please call us at 1-888-233-5935.If you would like to ask TennCare[SM] a question about your dental plan, or any other issue about your TennCare[SM] coverage, please call them at 1-800-669-1851. Please call Doral at 1-888-233-5935 if you have any ideas for changes in the program.

Special Needs

If you need your dental plan information in another language, Braille, or in any other way to accommodate your needs, please call Doral Dental at 1-888-233-5935. **We will be happy to give you the information in a format that you can use. Interpretation and translation services are available to you for free by calling Doral.**

Para ordenar una copia del libro del miembro en español, por favor llame o escriba a Doral al:

Doral Dental Tennessee, LLC
12121 N. Corporate Parkway
Mequon, WI 53092
1-888-233-5935

Transportation

If you need transportation, please call Doral at 1-888-233-5935. We can give you the phone number of the people you can call to get a ride to your dental appointment. This ride will not cost you anything. You can get a ride for an emergency by calling 911 or a local ambulance service.

Advance Directives

When people are very sick, it is possible for machines and medicine to keep them alive when they might otherwise die. Under the Tennessee Right to Natural Death Act, you have the right to decide if you want to be kept alive by these machines and medicine and for how long. You can do this with a "living will".

A living will must be filled out while you can still think for yourself. Your living will needs to be signed in front of two people. These people cannot be:

1. Related to you by blood or marriage
2. Entitled to any of your belongings after you die
3. Your doctor or the employees in their office where you are a patient

You should make three copies of your living will. They should be kept:

1. With your Primary Care Physician (PCP)
2. A person you trust to make medical decisions for you and
3. With your other important papers

Once you sign your living will it is your rule even if you are unable to speak. If you would like to change your living will, you can at any time while you can still speak for yourself. You can find living will forms in your MCO member handbook. You can fill those forms out if you like.

Co-payment (or Co-pay)

A co-payment is when you have to pay any part of your bill each time you get certain dental services. This is a fixed charge. TennCare[SM] sets the copay amounts based on your income. Not all members have a co-pay. To find out what your copay is, please call Doral at 1-888-233-5935. We will tell you how much money to bring with you to your dental appointment, or you can look at the copay table below. You will never have a co-pay for "preventive services". If you would like to know if the service that you are going to get is a "preventive service", please refer to the table on page x or call Doral. For example, if you go to the dentist on Monday and have a filling you will have to pay your copay of ($0, $15, or $25) and Doral will pay the rest. If you go back to the dentist on Tuesday and have another filling, you will have to pay your copay of ($0, $15, or $25) and Doral will pay the rest.

You are responsible for your assigned copayment prior to your dental treatment. If you do not pay your copay, your dental provider, TennCare[SM] or Doral may utilize whatever legal actions are available to collect these copay amounts. HOWEVER, NO ONE – NO MATTER WHAT HIS OR HER INCOME IS – WILL HAVE TO PAY A COPAYMENT FOR MEDICALLY NECESSARY PREVENTIVE CARE.

After January 1st, 2003	0% - 100% of Poverty	101% - 199% of Poverty	200% and over of Poverty
Dental cost per visit	$0	$15	$25

Maximum Out of Pocket Expenses

TennCare[SM] will not make you pay more than a set amount for the year in copayments. Once you have paid enough copayments that you have reached your "maximum", you will not have any more copayments for covered services for that year. To find out if you have reached your maximum copayment limit, please contact Doral at 1-888-233-5935, or you can look at the Maximum Limit table below. This is a fixed limit. TennCare[SM] sets the limit amounts. Not all members have a maximum.

After October 1st, 2003	0% - 100% of Poverty	101% - 199% of Poverty	200% and over of Poverty
	No Maximum, because there is no copay	$1,000 for individuals; $2,000 for families	$2,000 for individuals; $4,000 for families

None of the dentists or other specialists in our plan can refuse to give you medically necessary service because you fail to pay your copayments. But if you are able to pay and are simply unwilling to pay them, we will ask TennCare [SM] to take you off our plan. This is called disenrollment.

Unfair Treatment Complaint

Federal law says that unfair treatment is not allowed. No one can be treated in a different way because of race, color, birthplace, language, sex, age, beliefs or disability.
If you feel that you have been treated unfairly for any of these reasons, you have the right to complain. We do not allow unfair treatment in Doral Dental.

We need the following facts so we can look into your complaint. If you need help to fill out this page, let us know.

1. **Are you filing this complaint for yourself? ☐ Yes ☐ No**
   If yes, go to question number 2.
   If no, tell us your name: _____
   Give us a phone number where we can reach you: (_____) _____

2. **What is the name of the person you feel was treated unfairly?**

Name of Person You Feel Was Treated Unfairly _____ _____ Last First Middle Initial			**Date of Birth** _____ / _____ / _____ Month Day Year
Full Mailing Address: _____ _____ Street Number and Name, Rural Route, Apartment Number, Lot Number, PO Box, etc.			**Social Security Number:**
City:	**State:**	**Zip:**	Daytime Phone ( ) Evening Phone ( )

3. Who do you think treated this person unfairly?

Name _____

Address _____

City, State, and Zip Code _____

Phone Number (_____)_____ - or - (_____)_____

4. Give us facts about the unfair treatment.

Check the box or boxes that you think were the reason for the unfair treatment.

Race ☐ Color ☐ Birthplace ☐ Language spoken ☐ Sex ☐

Religion ☐ Beliefs ☐ Age ☐ Disability ☐

What date did the unfair treatment take place? _____

Do you think it has happened other times? ☐ Yes ☐ No If yes, how many other times? _____

Have you complained about this problem before and tried to have it stopped? ☐ Yes ☐ No

If yes, who have you talked to about it? Name:

_____

When did you talk to them about it? _____

Have you filed this complaint with another federal, state, or local agency? ☐ Yes ☐ No

Have you filed this complaint with any federal or state court? ☐ Yes ☐ No

If yes, check all that apply. Federal agency ☐ Federal court ☐
State agency ☐ State court ☐ Local agency ☐

If yes, tell us the name of the contact person at the agency/court where you filed the complaint.

Name _____

Agency/Court Name _____

Address _____

City, State, and Zip Code _____

Phone Number (____)_____

6. In your own words, tell us what happened. You can attach more pages if you need them.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please sign below. Attach any other information that you think will be helpful.

Sign here X_____ **Date:** _____

If you filled out this page for someone else, sign here. X _____

[Note: if you helped someone file this complaint, you don't have to sign.]

Print your name: _____ **Date:** _____

Mail these pages to: Doral Dental, LLC
Attn: Director of Non-discrimination Compliance
12121 N Corporate Parkway
Mequon, WI 53092

If you have questions, please call (615) 741-0155 or 1-800-342-3145 (toll-free) for help.

To get help in another language, call one of these numbers:

Language	Toll Free Number	Nashville Number
Arabic	1-877-652-3046	313-9840
Bosnian	1-877-652-3069	313-9382
Kurdish-Badinani	1-877-652-3046	313-9840
Kurdish-Sorani	1-877-652-3046	313-9840
Somali	1-877-652-3054	313-9894
Spanish	1-800-254-7568	227-7568
Vietnamese	1-800-269-4901	313-9899

ATTACHMENT 2
CURRENT DENTAL NETWORK

NAME	CITY
ABERNATHY FRED H.	PULASKI
ACOSTA JOHN	MEMPHIS
ADAMS GEORGE A.	NASHVILLE
ADAMS, JR. GEORGE A.	NASHVILLE
ADAMS, JR. GEORGE A.	NASHVILLE
ADAMS-BROWNE KAYE Y.	MEMPHIS
ADKINS FRAN E.	MURFREESBORO
ADKINS FRAN E.	MURFREESBORO
AKHRASS SAM	KINGSPORT
AKHRASS SAM	MEMPHIS
AKHRASS SAM	NOLENSVILLE
AKHRASS SAM	LYNCHBURG
AKHRASS SAM	HARTSVILLE
AKHRASS SAM	COLUMBIA
AKHRASS SAM	SPARTA
AKHRASS SAM	BRENTWOOD
AKHRASS SAM	WAVERLY
AKHRASS SAM	MCMINNVILLE
AKHRASS SAM	SHELBYVILLE
AKHRASS SAM	COKEVILLE
AKHRASS SAM	CROSSVILLE
AKHRASS SAM	ERIN
AKHRASS SAM	SHELBYVILLE
AKHRASS SAM	KINGSPORT
AKHRASS SAM	MEMPHIS
AKHRASS SAM	NOLENSVILLE
AKHRASS SAM	BRENTWOOD
AKHRASS SAM	LYNCHBURG
AKHRASS SAM	HARTSVILLE
AKHRASS SAM	COLUMBIA
AKHRASS SAM	SPARTA
AKHRASS SAM	ERIN
AKHRASS SAM	WAVERLY
AKHRASS SAM	MCMINNVILLE
AKHRASS SAM	COKEVILLE
ALBRIGHT JIMMY E.	MEMPHIS
ALBURY, JR. CHARLES D.	NASHVILLE
ALBURY, JR. CHARLES D.	NASHVILLE
ALBURY, JR. CHARLES D.	NASHVILLE
ALBURY, JR. CHARLES D.	NASHVILLE
ALBURY, JR. CHARLES D.	DICKSON
ALBURY, JR. CHARLES D.	NASHVILLE
ALBURY, JR. CHARLES D.	DICKSON
ALBURY, JR. CHARLES D.	NASHVILLE
ALBURY, JR. CHARLES D.	NASHVILLE
ALDEN FRANK H.	JOHNSON CITY

ALDEN	JOHN D.	COLUMBIA
ALEXANDER	CARLOS D.	MEMPHIS
ALEXANDER	CARLOS D.	MEMPHIS
ALEXANDER	CARLOS D.	MEMPHIS
ALEXANDER	MORRIS D.	SAVANNAH
ALISSANDRATOS	GEORGE L.	SMYRNA
ALLEN	JAMES D.	NASHVILLE
ALPERIN	MURRAY S.	MEMPHIS
ALPERIN	MURRAY S.	MEMPHIS
AMMAL	VEENA V.	MEMPHIS
ANDERS	CHARLES W.	JELLICO
ANDERSON	BARRY D.	NEWPORT
ANDERSON	JAMES GREGO	CROSSVILLE
ANDERSON	JAMES GREGO	OAK RIDGE
ANDERSON	JAMES GREGO	CROSSVILLE
ANDERSON	JAMES GREGO	POWELL
ANDERSON	JAMES GREGO	POWELL
ANDERSON	TONYA M.	MEMPHIS
ANDERSON	TONYA M.	MEMPHIS
ANDERSON, III	ARTHUR N.	NASHVILLE
ANDREWS	DAVID K.	LEWISBURG
ANDREWS	DAVID K.	LEWISBURG
ANDREWS	DAVID K.	COLUMBIA
ANDREWS	WILLIAM F.	JACKSON
AREHART	STEPHEN R.	OAK RIDGE
ARMBRISTER	MELISSA H.	GREENEVILLE
ATKINS	TANDRA F.	MEMPHIS
ATKINSON	ROBYN I.	MURFREESBORO
ATKINSON	VINCENT B.	MURFREESBORO
ATKINSON	VINCENT B.	LYNCHBURG
ATKINSON	VINCENT B.	LYNCHBURG
ATKINSON	VINCENT B.	MURFREESBORO
AZHDARI	SHAHLA	FAIRVIEW
BACON	LARRY A.	BRISTOL
BACON	LARRY A.	JOHNSON CITY
BACON	LARRY A.	KINGSPORT
BACON	LARRY A.	BRISTOL
BACON	LARRY A.	JOHNSON CITY
BACON	PAUL H.	CLEVELAND
BADDOUR	HARRY M.	JACKSON
BADDOUR	HARRY M.	PARSONS
BADDOUR	HARRY M.	PARSONS
BAIRD, JR	GORDON	HUNTSVILLE
BAKELAAR	TIMOTHY	BARTLETT
BAKELAAR	TIMOTHY	BARTLETT
BAKER	CLARENCE E.	MARTIN
BAKER, JR.	ELBERT W.	NASHVILLE
BALLARD	STEVE D.	MEMPHIS
BANKSTON, JR.	CARL W.	GALLATIN
BANKSTON, JR.	CARL W.	NASHVILLE
BANKSTON, JR.	CARL W.	NASHVILLE
BARNES	JAMES P.	GERMANTOWN
BARNES	JAMES P.	MEMPHIS
BARNES	JAMES P.	GERMANTOWN

BARNES	JAMES P.	MEMPHIS
BARNES	JEFF	SMITHVILLE
BATES	JOHNNY M.	WAYNESBORO
BATTLE	TRACIE M.	FAYETTEVILLE
BEALS	R. DOUGLAS	KNOXVILLE
BEASLEY	JOHN M.	LAWRENCEBURG
BEAUCHAMP	KARYL J.	CLARKSVILLE
BECK	BARRY W.	NASHVILLE
BECK	BARRY W.	NASHVILLE
BECK	BARRY W.	NASHVILLE
BELCHER	ERVIN	HOHENWALD
BELL	J. WILLIAM	KNOXVILLE
BELL	RONALD E.	SELMER
BELLOTT, JR.	DONALD J.	MEMPHIS
BETHEA	DONALD	MADISON
BETTIS	VICTORIA C.	JOHNSON CITY
BEWICK	ROBERT K.	MCMINNVILLE
BILES	PHILIP K.	TULLAHOMA
BIRDWELL	BEN	MORRISTOWN
BIVENS	DARRYL A.	LYLES
BLACKISTON	BENJAMIN T.	CHATTANOOGA
BLACKISTON	BENJAMIN T.	CHATTANOOGA
BLANKENSHIP	JIMMY P.	JACKSON
BLANKENSHIP	JIMMY P.	JACKSON
BLANKENSHIP	JIMMY P.	JACKSON
BLANTON	HORACE D.	KNOXVILLE
BLEN	MICHAEL D.	BARTLETT
BLEN	MICHAEL D.	BARTLETT
BLOURCHIAN	ALLEN A.	ANTIOCH
BOAZ	NICHOLE E.	CHATTANOOGA
BOBO	MICHAEL L.	UNION CITY
BOBO	MICHAEL L.	UNION CITY
BOBO	MICHAEL L.	UNION CITY
BOBO	MICHAEL L.	UNION CITY
BONNETT	RONALD G.	GREENEVILLE
BONNETT	RONALD G.	NEWPORT
BONNETT	RONALD G.	MORRISTOWN
BONNETT	RONALD G.	NEWPORT
BONNETT	RONALD G.	GREENEVILLE
BOUCEK	GREGORY W.	MEMPHIS
BOUCEK	GREGORY W.	MEMPHIS
BOUCEK	GREGORY W.	MEMPHIS
BOWERS	BRIT E.	JOHNSON CITY
BOWMAN	MICHAEL E.	LOUDON
BOYD	CHASE	CLARKSVILLE
BOYD	SCOTT B.	NASHVILLE
BRADFORD	ROBERTS J.	GREENEVILLE
BRADSHAW	DANIEL W.	ELIZABETHTON
BRADSHAW	DANIEL W.	JOHNSON CITY
BRADSHAW	DANIEL W.	ELIZABETHTON
BRADSHAW	JOHN W.	ELIZABETHTON
BRADSHAW	JOHN W.	ELIZABETHTON
BRADSHAW	JOHN W.	JOHNSON CITY
BRADSHAW	JOHN W.	JOHNSON CITY

BRADSHAW	JOHN W.	JOHNSON CITY
BRAID	MARTHA "JOD	DYERSBURG
BRANCH	RODERICK A.	MEMPHIS
BRANNEN	JAMES E.	CLARKSVILLE
BRATTON	ROY R.	JOHNSON CITY
BRATTON	TERRANCE	NASHVILLE
BRATTON	TERRANCE	MURFREESBORO
BRATTON	TERRANCE	MURFREESBORO
BRAXTON	SONIA D.	MEMPHIS
BRINK	JOSHUA	COVINGTON
BRINK	JOSHUA	COVINGTON
BRITTON	NOAH D.	ROGERSVILLE
BROCK	GEORGE M.	HIXSON
BROCK	GEORGE M.	CHATTANOOGA
BROCK	GEORGE M.	HIXSON
BROD	ROBERT	NASHVILLE
BROWDER	THERESA B.	DAYTON
BROWN	CHRISTOPHER	SNEEDVILLE
BROWN	CHRISTOPHER	KNOXVILLE
BROWN	CHRISTOPHER	KNOXVILLE
BROWN	RONALD	PULASKI
BRUNSON	KENNETH	UNION CITY
BRUNSON	KENNETH	DYERSBURG
BRUNSON	KENNETH	UNION CITY
BRYANT	JERALD A.	COOKEVILLE
BRYANT	JERALD A.	COOKEVILLE
BUCHER	ANDREW	WOODBURY
BUFFORD-JONES	RENITA G.	BOLIVAR
BUFFORD-JONES	RENITA G.	BOLIVAR
BURCH	WALTER P.	MADISON
BURCHFIELD	DANIEL C.	GOODLETTSVILLE
BURCHFIELD	DANIEL C.	GOODLETTSVILLE
BURCHFIELD	DANIEL C.	GALLATIN
BURCHFIELD	DANIEL C.	SPRINGFIELD
BURCHFIELD	DANIEL C.	GALLATIN
BURCHFIELD	DANIEL C.	MADISON
BURCHFIELD	DANIEL C.	MADISON
BURCHFIELD	DANIEL C.	SPRINGFIELD
BURCHFIELD	DANIEL C.	HENDERSONVILLE
BURDESHAW	CHARLES A.	LEBANON
BURDESHAW	CHARLES A.	HERMITAGE
BURDESHAW	CHARLES A.	LEBANON
BURDINE	LES	KINGSPORT
BURDINE	LES	KINGSPORT
BURGESS	ANISSA	DICKSON
BURGESS	ANISSA	DICKSON
BURGESS	ANISSA	NASHVILLE
BURGESS	MIGUEL A.	NASHVILLE
BURNS	YVETTE L	HIXSON
BURNS	YVETTE L	HIXSON
BUSH	BYRON V.	NASHVILLE
BUTLER	GEORGE E.	NASHVILLE

BUTLER-MITCHE	JACQUELINE	SMYRNA
BUTURFF	RICHARD G.	JAMESTOWN
CADE	ALISA A.	ROGERSVILLE
CADE	ALISA A.	SNEEDVILLE
CADE	ALISA A.	CHURCH HILL
CADE	ALISA A.	SNEEDVILLE
CADE	ALISA A.	CHURCH HILL
CADE	JASON S.	KINGSPORT
CALDWELL	KENNETH M.	MEMPHIS
CALDWELL	ROBERT E.	MILLINGTON
CAMPBELL	WILLIAM D.	KNOXVILLE
CAMPBELL	WILLIAM D.	KNOXVILLE
CAMPBELL	WILLIAM D.	SEYMOUR
CANTRELL	JAMES O.	FAYETTEVILLE
CARLSON	ERIC R.	KNOXVILLE
CARLSON	ERIC R.	KNOXVILLE
CARR	DENEAN	MEMPHIS
CARR	DENEAN	JACKSON
CARR	DENEAN	STANTON
CARR	DENEAN	MEMPHIS
CARR	DENEAN	JACKSON
CARROCCIA	ANTHONY	CLARKSVILLE
CARRUTH	KENNETH	MEMPHIS
CARRUTH	KENNETH	MEMPHIS
CARTER	ELLEN P.	MEMPHIS
CARTER	JEFFREY	COOKEVILLE
CARTER	JEFFREY	DICKSON
CARTER	JEFFREY	FRANKLIN
CARTER	JEFFREY	NASHVILLE
CARTER	JEFFREY	ALGOOD
CARTER	JEFFREY	SPRINGFIELD
CARTER	JEFFREY	NASHVILLE
CARTER	JEFFREY	NASHVILLE
CARTER	JEFFREY	NASHVILLE
CARTER	JEFFREY	HERMITAGE
CARTER	JEFFREY	COOKEVILLE
CARTER	JEFFREY	ALGOOD
CARTER	JEFFREY	FRANKLIN
CARTER	JEFFREY	SPRINGFIELD
CARTER	JEFFREY	DICKSON
CARTER	JEFFREY	NASHVILLE
CARTER	JEFFREY	HERMITAGE
CASON	TERRENCE L.	NASHVILLE
CHAMBERS	RUSSELL G.	ALCOA
CHAPMAN	JAMES D.	WARTBURG
CHAPMAN	KEITH E.	FRANKLIN
CHATMAN	SARAH M.	JACKSON
CHEATHAM	DAVID R.	CLARKSVILLE
CHILDRESS	ROBERT	MANCHESTER
CHILES	JOHN W.	COLUMBIA
CHITALIA	SHARAD S.	MEMPHIS
CHRIST	CHARLES H.	BRISTOL
CHRISTIAN	SOLOMON	MEMPHIS
CHRISTIAN	SOLOMON	MEMPHIS

CHRISTION	TRACEY D.	MEMPHIS
CLAIBORNE	BURGIN E.	MEMPHIS
CLARK	HOWARD	BRENTWOOD
CLARK	HOWARD	FRANKLIN
CLARK	HOWARD	BRENTWOOD
CLARK	JEFFREY M.	GREENVILLE
CLAYTON	GEORGE	NASHVILLE
COHEN	ALKA V.	CORDOVA
COLEMAN	HARRY T.	MEMPHIS
COLEMAN	HELEN L.	SPRINGFIELD
COLLINS	MARK	KNOXVILLE
COLLINS	MARK	SEYMOUR
COLLINS	MARK	MORRISTOWN
COLLINS	MARK	KNOXVILLE
COLLINS	MARK	MORRISTOWN
COLSON	CYNTHIA	MCEWEN
CONLEY	ELIZABETH J	HIXSON
CONLEY	ELIZABETH J	HIXSON
CONLEY	ELIZABETH J	CLEVELAND
CONLEY	ELIZABETH J	CLEVELAND
CONLEY	RICHARD S.	NASHVILLE
CONLEY	RICHARD S.	NASHVILLE
CONLEY	RICHARD S.	NASHVILLE
CONTRACTOR	HAMIR	PIKEVILLE
CONTRACTOR	HAMIR	PIKEVILLE
CONTRACTOR	HAMIR	ATHENS
COOPER	ERNEST W.	JOHNSON CITY
COOPER	JOEL	NASHVILLE
COOPER	JOEL	BRENTWOOD
COOPER	JOEL	BRENTWOOD
COOPER, SR.	LINDSEY W.	NASHVILLE
COPELAND	VINCENT H.	MEMPHIS
CORDICE	NORMAN H.	MT. JULIET
COURTNEY	RICK B.	WINCHESTER
COVINGTON	JOHN	MEMPHIS
COWAN	MICHAEL L.	SODDY DAISY
COWAN	MICHAEL L.	SODDY DAISY
COX	ANDREW R.	HENDERSONVILLE
COX	DONALD E.	LEBANON
COX	DONALD E.	LEBANON
COX	DONALD E.	MADISON
COX	DONALD E.	MADISON
COX	DONALD E.	HERMITAGE
COX	SUSAN H.	DYERSBURG
CRAWFORD	MARY F.	MEMPHIS
CRENSHAW	JERE W.	MCKENZIE
CRENSHAW	JERE W.	MCKENZIE
CRENSHAW	JERE W.	UNION CITY
CROSS	A. SCOTT	JACKSON
CROSS	KENNETH E.	HARRISON
CROSS	NYLA G.	ONEIDA
CROSSLEY	J DAVID	MORRISTOWN
CROWDER	JOHN W.	JACKSON

CROWDER, JR. ROY E.	RIPLEY
CULBERTSON CHARLES C.	CHATTANOOGA
CULLUM PAUL E.	COLUMBIA
CUMMINGS DONALD E.	MURFREESBORO
CUNNINGHAM HEATH L.	CLARKSVILLE
CUNNINGHAM JASON E.	ERWIN
CURETON STEVEN	KINGSPORT
DANIEL ROBIN R.	NASHVILLE
DANIEL ROBIN R.	MURFREESBORO
DANIEL ROBIN R.	NASHVILLE
DANIEL ROBIN R.	NASHVILLE
DANIEL ROBIN R.	NASHVILLE
DANIEL ROBIN R.	MURFREESBORO
DANIELS ALLEN D.	HUNTSVILLE
DAVE AJAY K.	MEMPHIS
DAVIS WILLIAM P.	NASHVILLE
DAWSON TOYA P.	MEMPHIS
DAY RONALD	JOHNSON CITY
DAY RONALD	ERWIN
DAY RONALD	JOHNSON CITY
DAY RONALD	ERWIN
DAY RONALD	JOHNSON CITY
DEASON DARRYL T.	WOODBURY
DEATON RANDALL N.	ADAMSVILLE
DEBOW DWIGHT A.	KINGSPORT
DEBOW DWIGHT A.	BRISTOL
DEBOW DWIGHT A.	BRISTOL
DECOLIBUS KATHERINE A	BARTLETT
DEDMON JOHN M.	CROSSVILLE
DEDMON JOHN M.	BYRDSTOWN
DEDMON JOHN M.	LIVINGSTON
DEDMON JOHN M.	WOODBURY
DEDMON JOHN M.	SPARTA
DEDMON JOHN M.	MCMINNVILLE
DEDMON JOHN M.	SPENCER
DEDMON JOHN M.	CARTHAGE
DEDMON JOHN M.	LAFAYETTE
DEDMON JOHN M.	COOKEVILLE
DEDMON JOHN M.	COOKEVILLE
DEDMON JOHN M.	CARTHAGE
DEDMON JOHN M.	GAINESBORO
DEDMON JOHN M.	GAINESBORO
DEDMON JOHN M.	CROSSVILLE
DEDMON JOHN M.	LIVINGSTON
DEDMON JOHN M.	BYRDSTOWN
DEDMON JOHN M.	CELINA
DEDMON JOHN M.	SMITHVILLE
DEDMON JOHN M.	WOODBURY
DEDMON JOHN M.	SPARTA
DEDMON JOHN M.	CELINA
DEDMON JOHN M.	SPENCER
DEDMON JOHN M.	MCMINNVILLE
DEDMON JOHN M.	LAFAYETTE
DEEDS LARY W.	CLARKSVILLE

DELAINE	CHARLES	SNEEDVILLE
DENNY	DAVID M.	NASHVILLE
DETARI	BRIAN D.	CHATTANOOGA
DEVALL	TERRY M.	COLLIERVILLE
DEVALL	TERRY M.	COLLIERVILLE
DEWALD	ERNEST	CLARKSVILLE
DILLARD	KEVIN K.	WOODBURY
DOCTORA	JOSEPH S.	SPRING HILL
DOCTORA	JOSEPH S.	SMYRNA
DOCTORA	JOSEPH S.	KNOXVILLE
DOCTORA	JOSEPH S.	JACKSON
DOCTORA	JOSEPH S.	KNOXVILLE
DOCTORA	JOSEPH S.	JACKSON
DOCTORA	JOSEPH S.	SPRING HILL
DOHERTY	S. ADELE	MADISON
DONESKY	MELVIN K.	NEW TAZEWELL
DORMOIS	LARRY D.	MEMPHIS
DORSEY	TOMMY J.	NASHVILLE
DOTSON	PHILLIP L.	LAWRENCEBURG
DOUGLAS	JUSTIN L.	COLUMBIA
DOUGLAS	JUSTIN L.	KINGSPORT
DOUGLAS	JUSTIN L.	MEMPHIS
DOUGLAS	JUSTIN L.	KINGSPORT
DOUGLAS	JUSTIN L.	MEMPHIS
DOUGLAS	JUSTIN L.	WAVERLY
DOUGLAS	JUSTIN L.	NOLENSVILLE
DOUGLAS	JUSTIN L.	LYNCHBURG
DOUGLAS	JUSTIN L.	ERIN
DOUGLAS	JUSTIN L.	MCMINNVILLE
DOUGLAS	JUSTIN L.	NOLENSVILLE
DOUGLAS	JUSTIN L.	COKEVILLE
DOUGLAS	JUSTIN L.	SPARTA
DOUGLAS	JUSTIN L.	WAVERLY
DOUGLAS	JUSTIN L.	LYNCHBURG
DOUGLAS	JUSTIN L.	SPARTA
DOUGLAS	JUSTIN L.	COLUMBIA
DOUGLAS	JUSTIN L.	SHELBYVILLE
DOUGLAS	JUSTIN L.	SHELBYVILLE
DOUGLAS	JUSTIN L.	HARTSVILLE
DOUGLAS	JUSTIN L.	CROSSVILLE
DOUGLAS	JUSTIN L.	HARTSVILLE
DOUGLAS	JUSTIN L.	COKEVILLE
DOUGLAS	JUSTIN L.	ERIN
DOUGLAS	JUSTIN L.	MCMINNVILLE
DOUGLAS	JUSTIN L.	CROSSVILLE
DOUGLASS	JESSE B.	HARROGATE
DOVE	LAURA B.	MEMPHIS
DOYLE	MARION G.	MADISON
DREWRY	ALAN B.	FAYETTEVILLE
DRIVER	JERRY R.	GAINESBORO
DUBROW	JACOB REUBE	CHATTANOOGA
DUDZINSKI	DAVID	COOKEVILLE
DUGAN, JR.	JAMES L.	ATHENS
DUGAN, SR.	JAMES L.	ATHENS

DUGGER GREGORY G.	PULASKI
DUNKERSON CHARLES M.	PARIS
DUNLAP CHARLES I.	CHATTANOOGA
DUNN HERBERT J.	MORRISTOWN
DYCUS, JR. DILLARD C.	GAINESBORO
EALY TODD	OOLTEWAH
EBERTING JEFFREY J.	MARYVILLE
EBERTING JEFFREY J.	KNOXVILLE
EBERTING JEFFREY J.	KNOXVILLE
EBERTING JEFFREY J.	MARYVILLE
EDINGTON ERNEST M.	CLARKSVILLE
EILERS, JR CARL	KINGSPORT
EILERS, JR CARL	KINGSPORT
EILERS, JR CARL	JOHNSON CITY
ELKINS E. BRYAN	COWAN
ELLIS DONALD H.	BRISTOL
ELLIS ROGER	CLARKSVILLE
ELLIS ROGER	CLARKSVILLE
ELLIS ROGER	CLARKSVILLE
ELLIS SPENCER A.	ONEIDA
ELLIS STEVEN E.	LIVINGSTON
ELROD JAMES R.	GREENBACK
ENG TOW EUGENE T.	NASHVILLE
ESLINGER CHAD S.	CLEVELAND
ETTER TERRY L.	ESTILL SPRINGS
EVANS H. SIMPSON	MEMPHIS
EVANS JOSEPH	SPRING HILL
EVANS MARK D.	MARYVILLE
EWING LESLIE D.	NASHVILLE
EWING LESLIE D.	NASHVILLE
EWING LESLIE D.	NASHVILLE
EWING SABIN	NASHVILLE
EWING SABIN	NASHVILLE
EWING SABIN	NASHVILLE
EWING SABIN	SMYRNA
EWING SABIN	MCEWEN
EWING SABIN	SMYRNA
EWING SABIN	COOKEVILLE
EWING SABIN	NASHVILLE
EWING SABIN	MCEWEN
EWING SABIN	COOKEVILLE
EWING SABIN	NASHVILLE
FALEYE ADEOLA O.	BARTLETT
FANN BRIAN D.	COLUMBIA
FANN BRIAN D.	COLUMBIA
FARMER JEFFERY R.	MURFREESBORO
FARRIS LARRY E.	SPRINGFIELD
FELDER HARRY	NASHVILLE
FELIX DUDLEY E.	NASHVILLE
FERGUSON JUSTIN	BRISTOL
FEWELL RICHARD D.	WINCHESTER
FEWELL RICHARD D.	MANCHESTER
FEWELL RICHARD D.	FAYETTEVILLE
FEWELL RICHARD D.	MANCHESTER

FEWELL	RICHARD D.	FAYETTEVILLE
FEWELL	RICHARD D.	WINCHESTER
FEWELL	RICHARD D.	TULLAHOMA
FIELDS	ROBERT M.	MILAN
FINNEY	GLENN B.	ROGERSVILLE
FISHER	JACK C.	MEMPHIS
FISHER	JACK C.	DYERSBURG
FISHER	JACK C.	MEMPHIS
FISHER	KEVIN M.	SPRINGFIELD
FLANAGAN	DON F.	CLEVELAND
FLANAGAN	DON F.	HIXSON
FLANAGAN	DON F.	CROSSVILLE
FLANAGAN	DON F.	CLEVELAND
FLANAGAN	DON F.	CROSSVILLE
FLANAGAN	DON F.	HIXSON
FLEMING	CLARANELL H	MADISON
FLORIANI	CLAYTON C.	MEMPHIS
FLORIANI	CLAYTON C.	COVINGTON
FLORIANI	CLAYTON C.	COVINGTON
FORBES	JOSEPH WOOD	JACKSON
FORDJOUR	ISAAC	MEMPHIS
FORDJOUR	ISAAC	DYERSBURG
FORDJOUR	ISAAC	DYERSBURG
FOSSICK	RAY B.	NASHVILLE
FOSTER	F. DON	CLINTON
FOUTCH	WOODARD D.	RUTLEDGE
FRAZIER	RODERICK V.	GOODLETTSVILLE
FREDERICKS	HAROLD E.	NASHVILLE
FRENCH, JR	EDGAR	KNOXVILLE
FRESHWATER	JOYCE R.	MEMPHIS
FUQUA	LEONARD R.	KINGSTON
FUSON	STEVE J.	MEMPHIS
FUSSELL	CHARLES S.	CHATTANOOGA
FUSSELL	CHARLES S.	CHATTANOOGA
GALBRAITH, JR	ROBERT H.	CLARKSVILLE
GARRETT	FLOYD A.	CORDOVA
GARRETT	KENNETH M.	CLARKSVILLE
GARRETT	MICHAEL C.	ROCKWOOD
GARRETT	MICHAEL C.	MORRISTOWN
GARRETT	MICHAEL C.	ROCKWOOD
GARRETT	MICHAEL C.	MORRISTOWN
GASTON	WILLIAM H.	NASHVILLE
GEISENHAVER	FRANK M.	BRISTOL
GETMAN	CHRISTOPHER	CORDOVA
GILLESPIE	JAMES H.	MARYVILLE
GILPIN	JERRY A.	ASHLAND CITY
GIPSON, II	LOVELACE P.	MEMPHIS
GIPSON, II	LOVELACE P.	MEMPHIS
GIPSON, II	LOVELACE P.	MEMPHIS
GIPSON, II	LOVELACE P.	MEMPHIS
GIPSON, II	LOVELACE P.	MEMPHIS
GIVENS	STEPHEN L.	SAVANNAH
GIVENS	STEPHEN L.	SAVANNAH

GLENN	BARRY	JACKSON
GLICK	KIM R.	TULLAHOMA
GLICK	KIM R.	TULLAHOMA
GORHAM, III	MATT J.	NASHVILLE
GORHAM, JR.	MATT J.	NASHVILLE
GOTCHER, JR.	JACK E.	KNOXVILLE
GOTCHER, JR.	JACK E.	KNOXVILLE
GOTCHER, JR.	JACK E.	KNOXVILLE
GOTCHER, JR.	JACK E.	SEVIERVILLE
GOTCHER, JR.	JACK E.	SEVIERVILLE
GRAHAM	STEPHEN D.	CHATTANOOGA
GRANT	RALPH G.	NASHVILLE
GRANT	RALPH G.	HERMITAGE
GRANT	RALPH G.	BELLEVUE
GRANT	RALPH G.	ANTIOCH
GRANT	RALPH G.	BELLEVUE
GRANT	RALPH G.	ANTIOCH
GRANT	RALPH G.	FRANKLIN
GRANT	RALPH G.	FRANKLIN
GRANT	RALPH G.	HERMITAGE
GRAVES	SHELDON M.	MEMPHIS
GREEN	LAWANA J.	WASHBURN
GREEN	WILLIAM P.	CLARKSVILLE
GREENE	PHILLIP T.	DICKSON
GREER	JOE C.	MEMPHIS
GREER	JOE C.	MEMPHIS
GROBMYER	GREG N.	BELLS
GROBMYER	GREG N.	BROWNSVILLE
GROBMYER	GREG N.	BROWNSVILLE
GROSS	KEVIN D.	KNOXVILLE
GROSS	KEVIN D.	LENOIR CITY
GROSS	KEVIN D.	OAK RIDGE
GROSS	KEVIN D.	ATHENS
GROSS	KEVIN D.	KNOXVILLE
GROSS	KEVIN D.	KNOXVILLE
GROSS	KEVIN D.	KNOXVILLE
GROSS	KEVIN D.	MARYVILLE
GROSS	KEVIN D.	LENOIR CITY
GROSS	KEVIN D.	SEVIERVILLE
GROSS	KEVIN D.	KNOXVILLE
GROSS	KEVIN D.	SEVIERVILLE
GROSS	KEVIN D.	OAK RIDGE
GROSS	KEVIN D.	KNOXVILLE
GROSS	KEVIN D.	ATHENS
GROSS	P. DWAYNE	KNOXVILLE
GROSS	P. DWAYNE	KNOXVILLE
GROSS	P. DWAYNE	ATHENS
GROSS	P. DWAYNE	KNOXVILLE
GROSS	P. DWAYNE	OAK RIDGE
GROSS	P. DWAYNE	SEVIERVILLE
GROSS	P. DWAYNE	OAK RIDGE
GROSS	P. DWAYNE	MARYVILLE
GROSS	P. DWAYNE	LENOIR CITY
GROSS	P. DWAYNE	KNOXVILLE

GROSS	P. DWAYNE	ATHENS
GROSS	P. DWAYNE	KNOXVILLE
GROSS	P. DWAYNE	SEVIERVILLE
GROSS	P. DWAYNE	LENOIR CITY
GROSS	P. DWAYNE	KNOXVILLE
GROSSHEIM, JR	RALPH	HOHENWALD
GROSSHEIM, JR	RALPH	SPRING HILL
GROSSHEIM, JR	RALPH	HOHENWALD
GUEST	RONNIE W.	BRISTOL
GUINN	RONEY O.W.	NASHVILLE
GURLEY	KEVIN D.	SMYRNA
GUTH, JR	MARVIN	MCEWEN
HALEY	SPENCER A.	NASHVILLE
HALEY	SPENCER A.	NASHVILLE
HAMLETT	BUTCH	RIPLEY
HAMLIN	MICHAEL L.	JOHNSON CITY
HAMLIN	MICHAEL L.	KINGSPORT
HAMLIN	MICHAEL L.	BRISTOL
HAMLIN	MICHAEL L.	JOHNSON CITY
HAMLIN	MICHAEL L.	KINGSPORT
HARDISON	FENTON PAYN	MURFREESBORO
HARDISON	MARK F.	MURFREESBORO
HARRIS	ANDREW	NASHVILLE
HARRIS	ANDREW	NASHVILLE
HARRIS	ANDREW	LEBANON
HARRIS	ETHEL P.	NASHVILLE
HARRIS	SANDRA	GOODLETTSVILLE
HARRIS	SANDRA	NASHVILLE
HARRIS	SANDRA	NASHVILLE
HARRIS	WILLIAM G.	OAK RIDGE
HARTMAN	KEVIN G.	GREENEVILLE
HARTZ	THOMAS K.	CLARKSVILLE
HASNANI	KARIM	JASPER
HATFIELD	REBECCA LEE	DUNLAP
HATHAWAY	JOHN L.	ELIZABETHTON
HATHAWAY	JOHN L.	JOHNSON CITY
HATHAWAY	JOHN L.	ELIZABETHTON
HAWS	THOMAS F.	KNOXVILLE
HAYES	ASHLEY L.	LINDEN
HEAD	PHILLIP W.	COLUMBIA
HEARD	RICHARD	HARTSVILLE
HEARD	RICHARD	ALGOOD
HEARD	RICHARD	LYNCHBURG
HEARD	RICHARD	BRENTWOOD
HEARD	RICHARD	HARTSVILLE
HEARD	RICHARD	COLUMBIA
HEARD	RICHARD	NOLENSVILLE
HEARD	RICHARD	SPARTA
HEARD	RICHARD	ALGOOD
HEARD	RICHARD	BRENTWOOD
HEARD	RICHARD	NOLENSVILLE
HEARD	RICHARD	LYNCHBURG
HEARD	RICHARD	ERIN

HEARD	RICHARD	CROSSVILLE
HEARD	RICHARD	LEWISBURG
HEARD	RICHARD	COLUMBIA
HEARD	RICHARD	MCMINNVILLE
HEARD	RICHARD	WAVERLY
HEARD	RICHARD	COKEVILLE
HEARD	RICHARD	LEWISBURG
HEARD	RICHARD	CROSSVILLE
HEARD	RICHARD	COKEVILLE
HEARD	RICHARD	MCMINNVILLE
HEARD	RICHARD	SHELBYVILLE
HEARD	RICHARD	WAVERLY
HEARD	RICHARD	ERIN
HEARD	RICHARD	SPARTA
HEARD	RICHARD	SHELBYVILLE
HEDGEPETH	BEVERLY D.	CELINA
HEDGEPETH	BEVERLY D.	WOODBURY
HEDGEPETH	BEVERLY D.	LIVINGSTON
HEDGEPETH	BEVERLY D.	BYRDSTOWN
HEDGEPETH	BEVERLY D.	SPARTA
HEDGEPETH	BEVERLY D.	MCMINNVILLE
HEDGEPETH	BEVERLY D.	SPENCER
HEDGEPETH	BEVERLY D.	CARTHAGE
HEDGEPETH	BEVERLY D.	COOKEVILLE
HEDGEPETH	BEVERLY D.	CROSSVILLE
HEDGEPETH	BEVERLY D.	SMITHVILLE
HEDGEPETH	BEVERLY D.	LAFAYETTE
HEDGEPETH	BEVERLY D.	SPARTA
HEDGEPETH	BEVERLY D.	CROSSVILLE
HEDGEPETH	BEVERLY D.	SMITHVILLE
HEDGEPETH	BEVERLY D.	LAFAYETTE
HEDGEPETH	BEVERLY D.	COOKEVILLE
HEDGEPETH	BEVERLY D.	CARTHAGE
HEDGEPETH	BEVERLY D.	MCMINNVILLE
HEDGEPETH	BEVERLY D.	WOODBURY
HEDGEPETH	BEVERLY D.	CELINA
HEDGEPETH	BEVERLY D.	BYRDSTOWN
HEDGEPETH	BEVERLY D.	LIVINGSTON
HEDGEPETH	BEVERLY D.	SPENCER
HENDRICKS	ALEXANDRA W	BRENTWOOD
HENDRICKS	JAMES R.	BRENTWOOD
HENDRICKS	RONALD	LENOIR
HENLEY	JOE	GREENVILLE
HEROS	FRED C.	MEMPHIS
HERRING	LACANAS N.	MEMPHIS
HERRING	LARRY W.	MEMPHIS
HICKS	JOSEPH	KNOXVILLE
HIGGS	WILSON CLAR	MADISON
HIGH	WILLIAM R.	KNOXVILLE
HIGH	WILLIAM R.	KNOXVILLE
HIGH	WILLIAM R.	KNOXVILLE
HIGH	WILLIAM R.	KNOXVILLE
HIGH	WILLIAM R.	KNOXVILLE
HIGH	WILLIAM R.	KNOXVILLE

HIGH	WILLIAM R.	KNOXVILLE
HIGHT	JAMES R.	PARSONS
HIGHT	JAMES R.	JACKSON
HIGHT	JAMES R.	PARSONS
HILGER	SHILO	BLOUNTVILLE
HILL	ANGELA	DECHERD
HILL	ANNE E.	MEMPHIS
HILL	ANNE E.	MEMPHIS
HILL	MELVIN L.	NASHVILLE
HILLS	ELLIOTT B.	CAMDEN
HINES	MORGAN B.	COLUMBIA
HINSON	HARRY PITTS	LAWRENCEBURG
HIPPENSTEEL	DAVID	CROSSVILLE
HIPPENSTEEL	DAVID	CROSSVILLE
HIPPS	DANIEL B.	SMYRNA
HOBBS, II	HARLEN D.	MCMINNVILLE
HOLIFIELD	MARK E.	PARSONS
HOLLERMAN	DAVIDA A.	MEMPHIS
HOLLERMAN	DAVIDA A.	MEMPHIS
HONEYCUTT	LARRY DEAN	MANCHESTER
HONEYCUTT	LARRY DEAN	MANCHESTER
HONEYCUTT	PAUL E.	MANCHESTER
HONEYCUTT	PAUL E.	MANCHESTER
HOOVER	JAMES M.	ADAMSVILLE
HOOVER	JAMES M.	ADAMSVILLE
HOPPER	BARRY	BLOUNTVILLE
HOPSON	PRICE E.	CLARKSVILLE
HORTON JR.	ROBERT L.	CAMDEN
HOWARD	BENJAMIN R.	WARTBURG
HOWARD	TAMARA J.	KNOXVILLE
HOWARD	WILLIAM S.	TURTLETOWN
HOWARD	WILLIAM S.	TELLICO PLAINS
HOWARD	WILLIAM S.	TURTLETOWN
HOWLETT	BRIAN K.	GAINESBORO
HOWLETT	BRIAN K.	GAINESBORO
HOWLETT	BRIAN K.	NASHVILLE
HRSTIC	IVANA	NASHVILLE
HUDSON	JOHN W.	KNOXVILLE
HUDSON	JOHN W.	CROSSVILLE
HUDSON	JOHN W.	COOKEVILLE
HUDSON	JOHN W.	KNOXVILLE
HUDSON	JOHN W.	CROSSVILLE
HUDSON	JOHN W.	COOKEVILLE
HUDSON	JOHN W.	KNOXVILLE
HUDSON, III	ROY A.	MEMPHIS
HUGHES	CHARLES H.	DYERSBURG
HULSE	EVON E.	GAINESBORO
HULSE	EVON E.	BAXTER
HULSE	EVON E.	SPARTA
HULSE	EVON E.	SPENCER
HULSE	EVON E.	DUNLAP
HULSE	EVON E.	CARTHAGE
HULSE	EVON E.	MARYVILLE
HULSE	EVON E.	PIGEON FORGE

HULSE	EVON E.	MAYNARDVILLE
HULSE	EVON E.	MOUNTAIN CITY
HULSE	EVON E.	JASPER
HULSE	EVON E.	LIVINGSTON
HULSE	EVON E.	CROSSVILLE
HULSE	EVON E.	IVYDELL
HULSE	EVON E.	PIKEVILLE
HULSE	EVON E.	SPRING CITY
HULSE	EVON E.	DECATUR
HULSE	EVON E.	CLEVELAND
HULSE	EVON E.	OCOEE
HULSE	EVON E.	MCMINNVILLLE
HULSE	EVON E.	ROCKWOOD
HULSE	EVON E.	HUNTSVILLE
HULSE	EVON E.	JAMESTOWN
HULSE	EVON E.	SNEEDVILLE
HULSE	EVON E.	BLOUNTVILLE
HULSE	EVON E.	SMITHVILLE
HULSE	EVON E.	CLINTON
HULSE	EVON E.	LOUDON
HULSE	EVON E.	JONESBORO
HULSE	EVON E.	HARTSVILLE
HULSE	EVON E.	MOSHEIM
HULSE	EVON E.	LEBANON
HULSE	EVON E.	MADISONVILLE
HULSE	EVON E.	NEW TAZEWELL
HULSE	EVON E.	NEWPORT
HULSE	EVON E.	MORRISTOWN
HULSE	EVON E.	RUTHLEDGE
HULSE	EVON E.	DANDRIDGE
HULSE	EVON E.	SURGOINSVILLE
HULSE	EVON E.	ELIZABETHTON
HULSE	EVON E.	CARTHAGE
HULSE	EVON E.	GAINESBORO
HULSE	EVON E.	MARYVILLE
HULSE	EVON E.	PIGEON FORGE
HULSE	EVON E.	MAYNARDVILLE
HULSE	EVON E.	LAFAYETTE
HULSE	EVON E.	BLOUNTVILLE
HULSE	EVON E.	JASPER
HULSE	EVON E.	ATHENS
HULSE	EVON E.	ERWIN
HULSE	EVON E.	WINCHESTER
HULSE	EVON E.	WINCHESTER
HULSE	EVON E.	MANCHESTER
HULSE	EVON E.	WOODBURY
HULSE	EVON E.	MOUNTAIN CITY
HULSE	EVON E.	JAMESTOWN
HULSE	EVON E.	HUNTSVILLE
HULSE	EVON E.	WARTBURG
HULSE	EVON E.	DUNLAP
HULSE	EVON E.	WARTBURG
HULSE	EVON E.	IVYDELL
HULSE	EVON E.	SPENCER

HULSE	EVON E.	SPARTA
HULSE	EVON E.	MANCHESTER
HULSE	EVON E.	PIKEVILLE
HULSE	EVON E.	LIVINGSTON
HULSE	EVON E.	ELIZABETHTON
HULSE	EVON E.	ROCKWOOD
HULSE	EVON E.	ATHENS
HULSE	EVON E.	OCOEE
HULSE	EVON E.	SPRING CITY
HULSE	EVON E.	DECATUR
HULSE	EVON E.	CLEVELAND
HULSE	EVON E.	BAXTER
HULSE	EVON E.	MORRISTOWN
HULSE	EVON E.	MOSHEIM
HULSE	EVON E.	SNEEDVILLE
HULSE	EVON E.	SURGOINSVILLE
HULSE	EVON E.	CROSSVILLE
HULSE	EVON E.	WOODBURY
HULSE	EVON E.	JONESBORO
HULSE	EVON E.	NEWPORT
HULSE	EVON E.	ERWIN
HULSE	EVON E.	DANDRIDGE
HULSE	EVON E.	LOUDON
HULSE	EVON E.	LEBANON
HULSE	EVON E.	HARTSVILLE
HULSE	EVON E.	LAFAYETTE
HULSE	EVON E.	SMITHVILLE
HULSE	EVON E.	CLINTON
HULSE	EVON E.	RUTHLEDGE
HULSE	EVON E.	MADISONVILLE
HULSE	EVON E.	NEW TAZEWELL
HULSE	RUSSELL	ELIZABETHTON
HULSE	RUSSELL	SURGOINSVILLE
HULSE	RUSSELL	MOSHEIM
HULSE	RUSSELL	ERWIN
HULSE	RUSSELL	SPENCER
HULSE	RUSSELL	DUNLAP
HULSE	RUSSELL	JONESBORO
HULSE	RUSSELL	SURGOINSVILLE
HULSE	RUSSELL	SNEEDVILLE
HULSE	RUSSELL	MOSHEIM
HULSE	RUSSELL	SNEEDVILLE
HULSE	RUSSELL	NEWPORT
HULSE	RUSSELL	NEWPORT
HULSE	RUSSELL	MORRISTOWN
HULSE	RUSSELL	DANDRIDGE
HULSE	RUSSELL	RUTHLEDGE
HULSE	RUSSELL	SPARTA
HULSE	RUSSELL	BAXTER
HULSE	RUSSELL	LIVINGSTON
HULSE	RUSSELL	JONESBORO
HULSE	RUSSELL	JAMESTOWN
HULSE	RUSSELL	MORRISTOWN
HULSE	RUSSELL	JASPER

HULSE	RUSSELL	PIGEON FORGE
HULSE	RUSSELL	CLEVELAND
HULSE	RUSSELL	DECATUR
HULSE	RUSSELL	SPRING CITY
HULSE	RUSSELL	PIKEVILLE
HULSE	RUSSELL	CROSSVILLE
HULSE	RUSSELL	JAMESTOWN
HULSE	RUSSELL	LIVINGSTON
HULSE	RUSSELL	BAXTER
HULSE	RUSSELL	CARTHAGE
HULSE	RUSSELL	SPARTA
HULSE	RUSSELL	SPENCER
HULSE	RUSSELL	JASPER
HULSE	RUSSELL	NEW TAZEWELL
HULSE	RUSSELL	BLOUNTVILLE
HULSE	RUSSELL	NEW TAZEWELL
HULSE	RUSSELL	MAYNARDVILLE
HULSE	RUSSELL	CARTHAGE
HULSE	RUSSELL	MOUNTAIN CITY
HULSE	RUSSELL	GAINESBORO
HULSE	RUSSELL	BLOUNTVILLE
HULSE	RUSSELL	MARYVILLE
HULSE	RUSSELL	PIGEON FORGE
HULSE	RUSSELL	MAYNARDVILLE
HULSE	RUSSELL	ELIZABETHTON
HULSE	RUSSELL	ERWIN
HULSE	RUSSELL	MOUNTAIN CITY
HULSE	RUSSELL	DUNLAP
HULSE	RUSSELL	IVYDELL
HULSE	RUSSELL	LAFAYETTE
HULSE	RUSSELL	CROSSVILLE
HULSE	RUSSELL	LAFAYETTE
HULSE	RUSSELL	DANDRIDGE
HULSE	RUSSELL	HARTSVILLE
HULSE	RUSSELL	LEBANON
HULSE	RUSSELL	WOODBURY
HULSE	RUSSELL	MANCHESTER
HULSE	RUSSELL	WINCHESTER
HULSE	RUSSELL	MANCHESTER
HULSE	RUSSELL	DECATUR
HULSE	RUSSELL	CLINTON
HULSE	RUSSELL	HUNTSVILLE
HULSE	RUSSELL	SMITHVILLE
HULSE	RUSSELL	HARTSVILLE
HULSE	RUSSELL	IVYDELL
HULSE	RUSSELL	HUNTSVILLE
HULSE	RUSSELL	MCMINNVILLLE
HULSE	RUSSELL	CLEVELAND
HULSE	RUSSELL	WARTBURG
HULSE	RUSSELL	OCOEE
HULSE	RUSSELL	LEBANON
HULSE	RUSSELL	ATHENS
HULSE	RUSSELL	ROCKWOOD
HULSE	RUSSELL	GAINESBORO

HULSE	RUSSELL	MARYVILLE
HULSE	RUSSELL	WOODBURY
HULSE	RUSSELL	SPRING CITY
HULSE	RUSSELL	WINCHESTER
HULSE	RUSSELL	MADISONVILLE
HULSE	RUSSELL	SMITHVILLE
HULSE	RUSSELL	ROCKWOOD
HULSE	RUSSELL	OCOEE
HULSE	RUSSELL	RUTHLEDGE
HULSE	RUSSELL	ATHENS
HULSE	RUSSELL	WARTBURG
HULSE	RUSSELL	PIKEVILLE
HULSE	RUSSELL	CLINTON
HULSE	RUSSELL	LOUDON
HULSE	RUSSELL	LOUDON
HULSE	RUSSELL	MADISONVILLE
HUNTER	WILLIAM L.	COLUMBIA
HURLEY	JOSEPH CLIN	WHITE PINE
HUSEIN	ASHRAF A.	BARTLETT
HUTTON	JAMES L.	COLUMBIA
JACKSON	BENITA S.	NASHVILLE
JACKSON	BENITA S.	NASHVILLE
JAFFREY	BRETT J.	CROSSVILLE
JAFFREY	BRETT J.	OAK RIDGE
JAFFREY	BRETT J.	OAK RIDGE
JAFFREY	BRETT J.	POWELL
JAFFREY	BRETT J.	POWELL
JANG	PETER	ATHENS
JEU	RICHARD C.	MEMPHIS
JOHNSON	DEAN	MEMPHIS
JOHNSON	DELILAH	BON AQUA
JOHNSON	MARK	ROCKWOOD
JOHNSON	MICHAEL R.	HIXSON
JOHNSON	RONALD E.	HENDERSON
JOHNSON, JR.	JAMES DAVID	OAK RIDGE
JOHNSON, JR.	JAMES DAVID	CROSSVILLE
JOHNSON, JR.	JAMES DAVID	POWELL
JOHNSON, JR.	JAMES DAVID	POWELL
JOHNSON, JR.	JAMES DAVID	CROSSVILLE
JOHNSONIUS	J.B.	MCKENZIE
JOHNSONIUS	J.B.	MCKENZIE
JOHNSONIUS	J.B.	PARIS
JOLLY	BRADLEY E.	BRENTWOOD
JONES	CHERYL D.	MEMPHIS
JONES	DEREK	PARIS
JONES	DEREK	CAMDEN
JONES	DEREK	CAMDEN
JONES	ROBERT H.	MCMINNVILLE
JONES	WILLIAM S.	KNOXVILLE
JONES, JR.	JOHN P.	KNOXVILLE
JORDAN	ROBERT D.	KNOXVILLE
KAIL	F. STEVEN	BROWNSVILLE
KAIL	F. STEVEN	BELLS
KAIL	F. STEVEN	BROWNSVILLE

KAKKAD	PRATAPARI	NASHVILLE
KAUFMAN	STEPHEN M.	ASHLAND CITY
KEEN	KATHERINE (	MURFREESBORO
KEEN	KATHERINE (	MURFREESBORO
KEEN	KATHERINE (	MANCHESTER
KEEN	KATHERINE (	MANCHESTER
KEENAN	KAREN S.	NASHVILLE
KELLY	DELBERT R.	CHATTANOOGA
KING	DEWITT H.	MEMPHIS
KING	MICHAEL	JACKSON
KING	RONALD	SNEEDVILLE
KINNEY	JOHN	CLARKSVILLE
KIRK	CLEO C.	MEMPHIS
KIRK	RUSSELL K.	LEBANON
KNAPP	THOMAS E.	HENDERSONVILLE
KNOELL	SARA	MURFREESBORO
KOPLOW	STEVE	SEVIERVILLE
KOPLOW	STEVE	SEVIERVILLE
KRUG	ARI	MCEWEN
KRUGER	BRIAN	HARTSVILLE
KRUSA	CHUCK J.	CROSSVILLE
KUTAS	TIMOTHY W.	MEMPHIS
LANGENBRUNNER	JOHN G.	JOHNSON CITY
LANGFORD	ALLEN K.	KNOXVILLE
LANGFORD	ALLEN K.	KNOXVILLE
LARKINS	KENYA	COVINGTON
LARKINS	KENYA	COVINGTON
LARKINS	TERESA K.	LEBANON
LARRY	BOBBY L.	HERMITAGE
LARRY	BOBBY L.	HERMITAGE
LARSON	JAMES E.	CHATTANOOGA
LATIMER	HARVEY L.	PLEASANT VIEW
LATIMER	HARVEY L.	PLEASANT VIEW
LATIMER	HARVEY L.	NASHVILLE
LAW	JOHN M.	MADISON
LEE	HENRY F.	ALCOA
LEGAN	HARRY	NASHVILLE
LEGAN	HARRY	NASHVILLE
LEGAN	HARRY	NASHVILLE
LEMINGS	ELAINE H.	ATHENS
LENTS, II	WILLIAM W.	NEWBERN
LEONARD	JOSEPH M.	BROWNSVILLE
LEONARD	JOSEPH M.	BELLS
LEONARD	JOSEPH M.	BROWNSVILLE
LEORDEAN	MIHAELA D.	MEMPHIS
LEVENTHAL	DEENE R.	CHATTANOOGA
LEVENTHAL	DEENE R.	CHATTANOOGA
LEWIS	BEVERLY H.	MEMPHIS
LEWIS	BEVERLY H.	MEMPHIS
LEWIS	MARY A.	MAYNARDVILLE
LIMA	RUTH O.	ASHLAND CITY
LIMA	RUTH O.	ASHLAND CITY
LIMA	RUTH O.	WAVERLY

LIMA	RUTH O.	FRANKLIN
LIMA	RUTH O.	ERIN
LIMA	RUTH O.	HARTSVILLE
LIMA	RUTH O.	DOVER
LIMA	RUTH O.	DICKSON
LIMA	RUTH O.	SPRINGFIELD
LIMA	RUTH O.	CLARKSVILLE
LIMA	RUTH O.	ERIN
LIMA	RUTH O.	LEBANON
LIMA	RUTH O.	MURFREESBORO
LIMA	RUTH O.	DECATUR
LIMA	RUTH O.	DUNLAP
LIMA	RUTH O.	JASPER
LIMA	RUTH O.	CLEVELAND
LIMA	RUTH O.	CHATTANOOGA
LIMA	RUTH O.	HENDERSONVILLE
LIMA	RUTH O.	FAIRVIEW
LIMA	RUTH O.	CLARKSVILLE
LIMA	RUTH O.	MURFREESBORO
LIMA	RUTH O.	NASHVILLE
LIMA	RUTH O.	WAVERLY
LIMA	RUTH O.	LEBANON
LIMA	RUTH O.	HARTSVILLE
LIMA	RUTH O.	DOVER
LIMA	RUTH O.	SPRINGFIELD
LIMA	RUTH O.	DICKSON
LIMA	RUTH O.	GALLATIN
LIMA	RUTH O.	FRANKLIN
LIMA	RUTH O.	CLARKSVILLE
LIMA	RUTH O.	SMYRNA
LIMA	RUTH O.	CHATTANOOGA
LIMA	RUTH O.	DECATUR
LIMA	RUTH O.	CLARKSVILLE
LIMA	RUTH O.	DUNLAP
LIMA	RUTH O.	EVENSVILLE
LIMA	RUTH O.	JASPER
LIMA	RUTH O.	CLEVELAND
LIMA	RUTH O.	SMYRNA
LIMA	RUTH O.	GALLATIN
LIMA	RUTH O.	NASHVILLE
LIMA	RUTH O.	FAIRVIEW
LIMA	RUTH O.	HENDERSONVILLE
LOCKE	CHARLES M.	TULLAHOMA
LOCKE	CHARLES M.	TULLAHOMA
LOCKE	CHARLES M.	TULLAHOMA
LONG	MARTIN K.	HIXSON
LONG	MARTIN K.	HIXSON
LOTT, SR.	JOHN B.	MEMPHIS
LOTT, SR.	JOHN B.	MEMPHIS
LOTT, SR.	JOHN B.	MEMPHIS
LUETHKE	LARRY D.	BRISTOL
LUETHKE	LARRY D.	JOHNSON CITY
LUETHKE	LARRY D.	KINGSPORT

LUETHKE LARRY D.	KINGSPORT
LUETHKE LARRY D.	KINGSPORT
LUETHKE LARRY D.	JOHNSON CITY
LUETHKE LARRY D.	KINGSPORT
LUNN DON M.	NASHVILLE
LUSK KELLEE	FRANKLIN
LUTHER, JR. PAUL F.	DICKSON
LYNN STEVE R.	TULLAHOMA
LYNN STEVE R.	TULLAHOMA
LYNN STEVE R.	TULLAHOMA
MACK HARRY R.	NASHVILLE
MACK HARRY R.	NASHVILLE
MACK HARRY R.	NASHVILLE
MAGEE DAVID A.	HENDERSON
MAHONEY EDWARD H.	SNEEDVILLE
MAHONEY EDWARD H.	SNEEDVILLE
MALHOTRA SHYAM K.	NASHVILLE
MALIN DAVID	BRENTWOOD
MALONE JR. HAROLD LEE	JOHNSON CITY
MALONEY JENNIFER	DICKSON
MALONEY JENNIFER	DICKSON
MANN JAMES H.	KNOXVILLE
MANN JAMES H.	KNOXVILLE
MANN JAMES H.	ATHENS
MANN JAMES H.	KNOXVILLE
MANN JAMES H.	SEVIERVILLE
MANN JAMES H.	OAK RIDGE
MANN JAMES H.	LENOIR CITY
MANN JAMES H.	KNOXVILLE
MANN JAMES H.	OAK RIDGE
MANN JAMES H.	KNOXVILLE
MANN JAMES H.	ATHENS
MANN JAMES H.	MARYVILLE
MANN JAMES H.	SEVIERVILLE
MANN JAMES H.	KNOXVILLE
MANN JAMES H.	LENOIR CITY
MANN JOHN	PULASKI
MAPPES MARK	NASHVILLE
MARRS STEVEN C.	PINEY FLATS
MARSHALL ANDREW	HARTSVILLE
MARTIN GERALD T.	SHELBYVILLE
MASSENGALE, JLENDELL	KNOXVILLE
MATIC LORETTA	NASHVILLE
MAY VALENCIA D.	MEMPHIS
MAYO STEPHEN P.	BEAN STATION
MCCALLEN, IIIJAMES F.	PARSONS
MCCAMISH DEWAYNE B.	CHATTANOOGA SIGNAL
MCCAMISH DEWAYNE B.	MOUNTAIN SIGNAL
MCCAMISH DEWAYNE B.	MOUNTAIN
MCCANN BILLY W.	MEMPHIS
MCCAWLEY JAMES R.	MURFREESBORO
MCCLAIN MICHAEL P.	PARIS
MCCONNELL TIMOTHY P.	SEYMOUR

MCCONNELL TIMOTHY P.	SEYMOUR
MCCONNELL TIMOTHY P.	MARYVILLE
MCCOY JAMES M.	KNOXVILLE
MCCOY JAMES M.	SEVIERVILLE
MCCOY JAMES M.	SEVIERVILLE
MCCOY JAMES M.	KNOXVILLE
MCCOY JAMES M.	KNOXVILLE
MCCULLAR BRUCE H.	MEMPHIS
MCCURDY TED	CLARKSVILLE
MCCURDY TED	CLARKSVILLE
MCCURDY TED	CLARKSVILLE
MCDONALD DAVID	CHATTANOOGA
MCDONALD JILL	PARIS
MCGOWAN JR. PAUL D.	KNOXVILLE
MCKENNA GARY E.	MORRISTOWN
MCKENNA SAMUEL	NASHVILLE
MCLAUGHLIN KENNETH D.	BRISTOL
MCLEMORE JOHN H.	JACKSON
MCLEMORE, IIIJAMES P.	JACKSON
MCLEOD BRUCE C.	GOODLETTSVILLE
MCLEOD BRUCE C.	MADISON
MCLEOD BRUCE C.	HENDERSONVILLE
MCLEOD BRUCE C.	GOODLETTSVILLE
MCLEOD BRUCE C.	MADISON
MCLEOD BRUCE C.	GALLATIN
MCLEOD BRUCE C.	SPRINGFIELD
MCLEOD BRUCE C.	SPRINGFIELD
MCLEOD BRUCE C.	GALLATIN
MCMAHON TERESA	KNOXVILLE
MCMASTERS MATTHEW P.	TRACY CITY
MCMASTERS MATTHEW P.	TRACY CITY
MCMASTERS MATTHEW P.	PULASKI
MCNEELY DAVID E.	ELIZABETHTON
MEDWEDEFF FRED M.	NASHVILLE
MEEKINS RICHARD D.	MEMPHIS
MEEKINS JR. RICHARD D.	MEMPHIS
MEEKINS JR. RICHARD D.	MEMPHIS
MEEKINS JR. RICHARD D.	MEMPHIS
MEFFORD JOHN	JOHNSON CITY
MEFFORD JOHN	JOHNSON CITY
MEFFORD JOHN	JOHNSON CITY
MELBOURNE KENT T.	KNOXVILLE
MELTON DAVID W.	HUMBOLDT
MERWIN DANIEL R.	JACKSON
MESICH LAWRENCE J.	CHATTANOOGA
MEYDRECH EDWARD A.	HIXSON
MEYDRECH EDWARD A.	HIXSON
MEYDRECH EDWARD A.	CLEVELAND
MEYDRECH EDWARD A.	CLEVELAND
MEYERS DONALD N.	MURFREESBORO
MEYERS DONALD N.	MURFREESBORO
MEYERS DONALD N.	ANTIOCH

MILLER ALEX J.	WHITE PINE
MILLER ESTILL L.	ELIZABETHTON
MILLER JASON K.	FRANKLIN
MILLER JASON K.	MURFREESBORO
MILLER JASON K.	MURFREESBORO
MILLER JOHNNY R.	UNION CITY
MILLER MARK A.	JACKSON
MILLER MARK A.	JACKSON
MILLER RICHARD J.	JEFFERSON CITY
MILLER RODRIC L.	MEMPHIS
MILLER, III PRESTON	JACKSON
MILLS JAMES B.	MILAN
MITCHELL MELVIN G.	PORTLAND
MODHVADIA VANRAJ M.	MEMPHIS
MOLLOY MICHAEL J.	KNOXVILLE
MONZON-BENAVIZINAMONG	BLAINE
MONZON-BENAVIZINAMONG	BLAINE
MOODY JR. EDWARD H.	MORRISTOWN
MOORE E. DARRYL	LEBANON
MOORE LYNDA M.	DAYTON
MOORE THOMAS W.	COLUMBIA
MORLEY DONALD KEIT	ELIZABETHTON
MORRIS KEITH D.	MEMPHIS
MORRIS KEITH D.	MEMPHIS
MORRIS KEITH D.	MEMPHIS
MORRIS KEITH D.	MEMPHIS
MORRISON BOBBY R.	CENTERVILLE
MOYE, JR. THOMAS D.	CROSSVILLE
MOYE, JR. THOMAS D.	OAK RIDGE
MOYE, JR. THOMAS D.	POWELL
MOYE, JR. THOMAS D.	POWELL
MOYE, JR. THOMAS D.	CROSSVILLE
MURPHY JAMES	CHATTANOOGA
MUSE CLAUDE D.	COPPERHILL
MUSTIFUL-MARTDENISE M.	MEMPHIS
MYERS LEE T.	OAKLAND
MYERS LEE T.	OAKLAND
MYERS LEE T.	MEMPHIS
MYERS LEE T.	MEMPHIS
MYERS LEE T.	MEMPHIS
MYERS, III RICHARD	KNOXVILLE
MYSINGER MIKE D.	KNOXVILLE
NESBITT PAULA E.	NASHVILLE
NESBITT PAULA E.	NASHVILLE
NETHERTON MICHAEL	MCMINNVILLE
NETHERTON MICHAEL	MCMINNVILLE
NEWBERRY PATRICIA J.	NASHVILLE
NEWBERRY, JR.HUEY	NASHVILLE
NEWSOM-BROUGHCORY L.	MEMPHIS
NEWSOM-BROUGHCORY L.	MEMPHIS
NEWSOM-BROUGHCORY L.	MEMPHIS
NGUYEN LY	DICKSON
NIXON RALPH M.	JACKSON
NKUNGULA TANIA C.	GAINESBORO

NKUNGULA	TANIA C.	GAINESBORO
NKUNGULA	TANIA C.	NASHVILLE
NOE	RONALD E.	LAKE CITY
NORTHCUTT	SARA B.	FRANKLIN
NUNLEY	REBECCA L.	JOHNSON CITY
NUNLEY	REBECCA L.	JOHNSON CITY
NUNLEY	REBECCA L.	JOHNSON CITY
NUNLEY	REBECCA L.	JOHNSON CITY
NUNN	MARTIN A.	NASHVILLE
ODDS	MARVO C.	LAVERGNE
OLLARD	G. STEPHEN	KNOXVILLE
OLLARD	G. STEPHEN	KNOXVILLE
OLLARD	G. STEPHEN	SEVIERVILLE
O'NEAL	JOE D.	MEMPHIS
ONSTOTT	THOMAS W.	SPRINGFIELD
OSBORN	DREW	MARYVILLE
OSBORN	JOHN C.	KNOXVILLE
OSBORN	JOHN C.	MAYNARDVILLE
OSBORN	JOHN C.	KNOXVILLE
OWENS	HEATHER H.	COLUMBIA
OWENS	JUNE H.	NASHVILLE
OWENS	WALTER R.	NASHVILLE
PACE	JAMES R.	NASHVILLE
PACK	TRACY	SHELBYVILLE
PACK	TRACY	SHELBYVILLE
PACK	TRACY	MURFREESBORO
PAFFRATH	JOHN S.	ERIN
PAGE	JOHN C.	MEMPHIS
PAGE	TOMMY W.	LEXINGTON
PARKER	MARSHALL	KNOXVILLE
PARKER, III	CHARLES O.	JOHNSON CITY
PARKS	ANITA J.	BOLIVAR
PARKS	ANITA J.	BOLIVAR
PARSONS	BUCKIE D.	LIVINGSTON
PARSONS, II	BUCKIE	LIVINGSTON
PATEL	ARVIND K.	LAVERGNE
PATEL	MINESH Y.	JACKSON
PATEL	SHAKU J.	TAZEWELL
PATEL	T.R.	JOHNSON CITY
PATTERSON	THOMAS C.	MEMPHIS
PATTERSON	VAUGHN	DECATUR
PATTERSON	VAUGHN	EVENSVILLE
PATTERSON	VAUGHN	EVENSVILLE
PATTERSON	VAUGHN	WINCHESTER
PATTERSON	VAUGHN	DUNLAP
PATTERSON	VAUGHN	BENTON
PATTERSON	VAUGHN	ALTAMONT
PATTERSON	VAUGHN	ATHENS
PATTERSON	VAUGHN	PIKEVILLE
PATTERSON	VAUGHN	CLEVELAND
PATTERSON	VAUGHN	JASPER
PATTERSON	VAUGHN	BENTON
PATTERSON	VAUGHN	WINCHESTER
PATTERSON	VAUGHN	DUNLAP

PATTERSON	VAUGHN	DECATUR
PATTERSON	VAUGHN	ALTAMONT
PATTERSON	VAUGHN	PIKEVILLE
PATTERSON	VAUGHN	ATHENS
PATTERSON	VAUGHN	JASPER
PAYNE	DERRICK D.	MEMPHIS
PAYNE	JACKSON L.	MEMPHIS
PECK	RUSSELL	MEMPHIS
PEEPLES	HAROLD C.	MADISON
PENDERGRASS	BARRY S.	CENTERVILLE
PERDUE	ED C.	NASHVILLE
PERDUE	ED C.	NASHVILLE
PERRY	ALDRICH T.	MURFREESBORO
PERRY	BENJAMIN C.	CHATTANOOGA
PESCE	CHARLES S.	ATHENS
PETTY	JOHN E.	TULLAHOMA
PICKERING	JAMES T.	KNOXVILLE
PITCHFORD	PATRICK R.	CLARKSVILLE
PITTENGER	DALE B.	KINGSPORT
PITTENGER	GINA R.	SMYRNA
PITTENGER	GINA R.	KINGSPORT
PITTENGER	GINA R.	KINGSPORT
PITTENGER	GINA R.	SMYRNA
POLK	ADOLFINA	NASHVILLE
POPP	THOMAS W.	DAYTON
POPP	THOMAS W.	CHATTANOOGA
POPP	THOMAS W.	DAYTON
PRESTON	CHARLES L.	DICKSON
PRICE	VINCENT J.	ERIN
PRICE	VINCENT J.	SPARTA
PRICE	VINCENT J.	MEMPHIS
PRICE	VINCENT J.	COLUMBIA
PRICE	VINCENT J.	HARTSVILLE
PRICE	VINCENT J.	LYNCHBURG
PRICE	VINCENT J.	NOLENSVILLE
PRICE	VINCENT J.	MEMPHIS
PRICE	VINCENT J.	WAVERLY
PRICE	VINCENT J.	MEMPHIS
PRICE	VINCENT J.	KINGSPORT
PRICE	VINCENT J.	SHELBYVILLE
PRICE	VINCENT J.	MEMPHIS
PRICE	VINCENT J.	KINGSPORT
PRICE	VINCENT J.	MEMPHIS
PRICE	VINCENT J.	NOLENSVILLE
PRICE	VINCENT J.	LYNCHBURG
PRICE	VINCENT J.	HARTSVILLE
PRICE	VINCENT J.	COLUMBIA
PRICE	VINCENT J.	SPARTA
PRICE	VINCENT J.	ERIN
PRICE	VINCENT J.	COKEVILLE
PRICE	VINCENT J.	WAVERLY
PRICE	VINCENT J.	SHELBYVILLE
PRICE	VINCENT J.	COKEVILLE
PRICE	VINCENT J.	CROSSVILLE

PRICE	VINCENT J.	MCMINNVILLE
PRICE	VINCENT J.	CROSSVILLE
PRICE	VINCENT J.	MCMINNVILLE
PRICHARD, II	RICHARD J.	SODDY DAISY
PRIMM	JOHN P.	WHITE BLUFF
PRINCE	RANDALL P.	DYERSBURG
PROPHETE	ADELINE	MEMPHIS
PRYOR	GLORIA J.	MEMPHIS
PRYOR	GLORIA J.	MEMPHIS
PRYOR	GLORIA J.	MEMPHIS
PRYSE	JOHN C.	LA FOLLETTE
PUCKETT	JOHN H.	KINGSTON
PUCKETT	JOHN H.	KINGSTON
RABI	AHMAD	NASHVILLE
RAINEY	IRVIN	JACKSON
RANKIN, JR.	JOHN W.	MEMPHIS
RASNER	DAVID S.	SOMMERVILLE
RATLIFF	CYNTHIA J.	BRISTOL
RATLIFF	CYNTHIA J.	BRISTOL
RAY	LEONARD G.	ASHLAND CITY
RAY	STEPHEN L.	MARYVILLE
RAY	TIMOTHY H.	CLEVELAND
READ	DANIEL S.	KNOXVILLE
READ	JAMES D.	JACKSON
REDDI	SANJA P.	NASHVILLE
REDFORD	DONALD S.	BRISTOL
REED	JAMES M.	GALLATIN
REED	LON	JOHNSON CITY
REED	RONALD J.	DYERSBURG
REESE	CHERYL D.	RIPLEY
REESE	CHERYL D.	RIPLEY
RENYE	JOHN E.	CHURCH HILL
REYNOLDS	WILLIAM G.	CLEVELAND
REZBA	STEVEN H.	FRANKLIN
RIBEIRO	RICHARD C.	CLARKSVILLE
RICHARDSON	DWAYNE	SOMERVILLE
RICHARDSON	ELISHA R.	NASHVILLE
RICHARDSON	ELISHA R.	NASHVILLE
RICHARDSON	ELISHA R.	NASHVILLE
RICHARDSON	ELISHA R.	NASHVILLE
RICHARDSON	GREGORY P.	GALLATIN
RICHARDSON	GREGORY P.	MADISON
RICHARDSON	GREGORY P.	GOODLETTSVILLE
RICHARDSON	GREGORY P.	SPRINGFIELD
RICHARDSON	GREGORY P.	GOODLETTSVILLE
RICHARDSON	GREGORY P.	SPRINGFIELD
RICHARDSON	GREGORY P.	HENDERSONVILLE
RICHARDSON	GREGORY P.	GALLATIN
RICHARDSON	GREGORY P.	MADISON
RICKMAN	SAMUEL K.	JACKSON
RIGGS	JAMES DANIE	LAWRENCEBURG
RIMER	CARSON	MURFREESBORO

RIMER	CARSON	MURFREESBORO
RITCHIE	EDWARD S.	LAFOLLETTE
RITCHIE	EDWARD S.	JELLICO
RITCHIE	EDWARD S.	JELLICO
RITCHIE	EDWARD S.	LAFOLLETTE
RIVERS	JAMES BENJA	FAIRFIELD GLADE
RIVERS	JAMES BENJA	FAIRFIELD GLADE
RIVERS	JAMES BENJA	KNOXVILLE
RIVERS	JAMES BENJA	KNOXVILLE
ROACH	C. DAVID	NASHVILLE
ROBINETTE	RICHARD L.	HOHENWALD
ROBINETTE	RICHARD L.	SPRING HILL
ROBINETTE	RICHARD L.	HOHENWALD
ROBINSON	JEREMY W.	COOKEVILLE
ROBINSON	QUINTON C.	MEMPHIS
RODRIGUEZ	CARLOS S.	UNION CITY
RODRIGUEZ	CARLOS S.	UNION CITY
ROGERS	FRANK T.	PHILADELPHIA
ROLIN	BARRY W.	NASHVILLE
ROLIN	BARRY W.	GOODLETTSVILLE
ROLIN	BARRY W.	GOODLETTSVILLE
ROLLINS	JAMES M.	HENDERSONVILLE
ROOKS	ROBERT N.	BROWNSVILLE
ROSS	ANGELA M.	NASHVILLE
ROSS	ANGELA M.	NASHVILLE
ROSS	RUTH E.	NASHVILLE
ROSS	RUTH E.	NASHVILLE
ROSS	RUTH E.	NASHVILLE
ROUSE	JUANITA A.	NASHVILLE
ROWLAND	CHRIS C.	MEMPHIS
ROWLAND	CHRIS C.	COLLIERVILLE
ROWLAND	CHRIS C.	COLLIERVILLE
ROWLAND	CHRIS C.	MEMPHIS
RUMPH JR.	THOMAS C.	CHATTANOOGA
RUNYON	RODNEY D.	GALLATIN
RUNYON	RODNEY D.	HARTSVILLE
RUNYON	RODNEY D.	GALLATIN
RUSH	RICHARD A.	CHATTANOOGA
RUSH	RICHARD A.	JASPER
RUSH	RICHARD A.	JASPER
RUSSELL	ANDREW D.	BROWNSVILLE
RUSSELL	CHARLES M.	HARROGATE
RUSSELL III	THOMAS D.	BROWNSVILLE
RUSSELL IV	THOMAS D.	BROWNSVILLE
SALAGE	RONALD J.	CLINTON
SALAGE	RONALD J.	WARTBURG
SALAGE	RONALD J.	WARTBURG
SALAZAR	JOSE L.	LYNCHBURG
SALAZAR	JOSE L.	COLUMBIA
SALAZAR	JOSE L.	NOLENSVILLE

SALAZAR	JOSE L.	KINGSPORT
SALAZAR	JOSE L.	SPARTA
SALAZAR	JOSE L.	ERIN
SALAZAR	JOSE L.	WAVERLY
SALAZAR	JOSE L.	COKEVILLE
SALAZAR	JOSE L.	MCMINNVILLE
SALAZAR	JOSE L.	SHELBYVILLE
SALAZAR	JOSE L.	LYNCHBURG
SALAZAR	JOSE L.	NOLENSVILLE
SALAZAR	JOSE L.	CROSSVILLE
SALAZAR	JOSE L.	HARTSVILLE
SALAZAR	JOSE L.	HARTSVILLE
SALAZAR	JOSE L.	CROSSVILLE
SALAZAR	JOSE L.	COKEVILLE
SALAZAR	JOSE L.	MEMPHIS
SALAZAR	JOSE L.	MEMPHIS
SALAZAR	JOSE L.	MCMINNVILLE
SALAZAR	JOSE L.	SHELBYVILLE
SALAZAR	JOSE L.	WAVERLY
SALAZAR	JOSE L.	SPARTA
SALAZAR	JOSE L.	KINGSPORT
SALAZAR	JOSE L.	COLUMBIA
SALAZAR	JOSE L.	ERIN
SALAZAR	JUAN C.	MEMPHIS
SAMMONS	STEPHEN J.	JACKSON
SANDUSKY	WALTER C.	MEMPHIS
SAWRIE	STEPHEN M.	CHATTANOOGA
SCALES	WILLIAM D.	NASHVILLE
SCALES	WILLIAM D.	NASHVILLE
SCALES	WILLIAM D.	NASHVILLE
SCANGA	SUSAN R.S.	NASHVILLE
SCHENCK	BRIAN	HIXSON
SCHILLING	NANCY L.	OOLTEWAH
SCHUH	ERIC	GALLATIN
SEAVER	THOMAS R.	JOHNSON CITY
SEBELIUS, JR.	CARL L.	MEMPHIS
SEITZ	EILEEN C.	NASHVILLE
SEXTON	STEPHEN	MEMPHIS
SHAIKH	KHALID N.	NASHVILLE
SHANKS	CARROLL R.	KNOXVILLE
SHANKS	CARROLL R.	KNOXVILLE
SHANKS	CARROLL R.	MARYVILLE
SHANKS	CARROLL R.	KNOXVILLE
SHANKS	CARROLL R.	KNOXVILLE
SHANKS	CHARLES	MARYVILLE
SHANKS	CHARLES	KNOXVILLE
SHANKS	CHARLES	MARYVILLE
SHANKS	CHARLES	KNOXVILLE
SHARP	THOMAS A.	KNOXVILLE
SHAW	JAMES F.	LA FOLLETTE
SHEA	JOHN K.	GALLATIN
SHEA	JOHN K.	SPRINGFIELD
SHEA	JOHN K.	HENDERSONVILLE

SHEA	JOHN K.	GOODLETTSVILLE
SHEA	JOHN K.	GOODLETTSVILLE
SHEA	JOHN K.	MADISON
SHEA	JOHN K.	GALLATIN
SHEA	JOHN K.	SPRINGFIELD
SHEA	JOHN K.	MADISON
SHELL	JON E.	SEVIERVILLE
SHEPHERD	CRAIG A.	GREENEVILLE
SHIPLEY	WILLIAM C.	BRISTOL
SHIPLEY	WILLIAM T.	COOKEVILLE
SHIRLEY	MICHAEL D.	MEMPHIS
SHOPE JR.	ZEB C.	MARYVILLE
SHORT	GEORGE M.	JACKSON
SIDWELL	IRA L.	NASHVILLE
SIGUR	SHELLEY A.	DICKSON
SIGUR	SHELLEY A.	DICKSON
SIMS	CAROL ANN	TRENTON
SINCLAIR	SEAN T.	MARYVILLE
SINES, SR.	JOHN A.	COLLEGEDALE
SINES, SR.	JOHN A.	BENTON
SINES, SR.	JOHN A.	COLLEGEDALE
SINGH	ANTARPREET	ANTIOCH
SINGH	ANTARPREET	ANTIOCH
SISK	EDWARD D.	PULASKI
SKIDMORE	ANGELA M.	MILLINGTON
SLATER	OTTO W.	SEYMOUR
SLATER	OTTO W.	MARYVILLE
SLATER	OTTO W.	SEYMOUR
SMILEY	KIM A.	NASHVILLE
SMITH	CHRISTOPHER	MANCHESTER
SMITH	DOUGLAS	CHURCH HILL
SMITH	DOUGLAS	CHURCH HILL
SMITH	HARRY R.	ELIZABETHTON
SMITH	JAMES RANDA	TULLAHOMA
SMITH	JAMES RANDA	FAYETTEVILLE
SMITH	JAMES RANDA	FAYETTEVILLE
SMITH	MARK C.	GREENEVILLE
SMITH	MARK C.	GREENEVILLE
SMITH	MARK C.	NEWPORT
SMITH	MICHAEL S.	KNOXVILLE
SMITH	RICHARD H.	DYERSBURG
SMITH	RICHARD H.	DYERSBURG
SMITH	ROBERT K.	MEMPHIS
SMITH	ROBERT W.	MEMPHIS
SMITH	ROOSEVELT S	NASHVILLE
SMITH	STEVEN F.	GREENEVILLE
SMITH	STEVEN F.	GREENEVILLE
SMITH	STEVEN F.	NEWPORT
SNELSON	STEPHANIE A	BRISTOL
SNELSON	STEPHANIE A	BRISTOL
SPARROW	ELIZABETH E	NASHVILLE
SPARROW	GERALD C.	NASHVILLE
SPEER	GRACE E.	LAKELAND

SPEER, JR. HAROLD G.	LAKELAND
SPELL, III CHARLIE	MEMPHIS
SPELL, III CHARLIE	FRAYSER
SPELL, III CHARLIE	MEMPHIS
SPELL, III CHARLIE	FRAYSER
SPELL, III CHARLIE	MEMPHIS
STANDIFER DENNIS W.	DAYTON
STANDIFER DENNIS W.	CHATTANOOGA
STANDIFER DENNIS W.	DAYTON
STANISLAV LEON E.	CLARKSVILLE
STANLEY ANN	LEBANON
STANLEY ANN	LEBANON
STAPLES RONALD C.	MEMPHIS
STAPLES RONALD C.	MEMPHIS
STAPLES RONALD C.	MEMPHIS
STARLING CRAIG	NASHVILLE
STEEL, JR. ROBERT E.	CHATTANOOGA
STEIN GILBERT G.	MEMPHIS
STEPHENS BILLIE M.	KNOXVILLE
STEVENS ALAN M.	GRAY
STINSON EUGENE W.	SEYMOUR
STINSON EUGENE W.	SEYMOUR
STINSON EUGENE W.	SEVIERVILLE
STONE JOHN H.	HARTSVILLE
STONE JOHN H.	KINGSPORT
STONE JOHN H.	MEMPHIS
STONE JOHN H.	LYNCHBURG
STONE JOHN H.	COKEVILLE
STONE JOHN H.	NOLENSVILLE
STONE JOHN H.	SHELBYVILLE
STONE JOHN H.	WAVERLY
STONE JOHN H.	ERIN
STONE JOHN H.	SPARTA
STONE JOHN H.	CROSSVILLE
STONE JOHN H.	HARTSVILLE
STONE JOHN H.	MCMINNVILLE
STONE JOHN H.	NOLENSVILLE
STONE JOHN H.	MEMPHIS
STONE JOHN H.	KINGSPORT
STONE JOHN H.	SHELBYVILLE
STONE JOHN H.	CROSSVILLE
STONE JOHN H.	MCMINNVILLE
STONE JOHN H.	COKEVILLE
STONE JOHN H.	COLUMBIA
STONE JOHN H.	LYNCHBURG
STONE JOHN H.	SPARTA
STONE JOHN H.	COLUMBIA
STONE JOHN H.	CELINA
STONE JOHN H.	ERIN
STONE JOHN H.	WAVERLY
STRINGFELLOW LOREN B.	MILLINGTON
STRINGFELLOW LOREN B.	MILLINGTON
STRITIKUS JOHN C.	DICKSON
SULLIVAN JERRY L.	UNION CITY

SULLIVAN JOHN H.	LEXINGTON
SULLIVAN LOYD T.	NASHVILLE
SULLIVAN PATRICIA L.	JACKSBORO
SUNDSTROM BRAD W.	CHATTANOOGA
SUNDSTROM BRAD W.	CHATTANOOGA
SWITZER-NADASRHONDA D.	NASHVILLE
TACKETT DANNY K.	JACKSBORO
TANNER JOHN E.	KINGSPORT
TAYLOR F. WILLIAM	HENDERSONVILLE
TAYLOR JEANNE M.	BRENTWOOD
TAYLOR-VINES JULIA A.	ELIZABETHTON
THERIAC AMY	UNION CITY
THETFORD WILLIAM B.	DICKSON
THETFORD WILLIAM B.	DICKSON
THOMAS CHARLES A.	CHATTANOOGA
THOMAS GREGORY A.	KNOXVILLE
THOMAS LARRY D.	LEWISBURG
THOMAS ROBERT D.	SAVANNAH
THOMPSON DWIGHT E.	MEMPHIS
THOMPSON J. ANDY	COOKEVILLE
THOMPSON THOMAS	LAWRENCEBURG
TOMPKINS, IIICHARLES F.	HARROGATE
TOMPKINS, IIICHARLES F.	HARROGATE
TOWNSEND CARMEL E.	MEMPHIS
TRAN NGOC	CORDOVA
TRAVIS DAVID B.	PARIS
TRICE SANDRA V.	NASHVILLE
TRIPLETT ORPHEUS L.	MEMPHIS
TROTTER DAVID G.	SEVIERVILLE
TROUTT ANDREW	CAMDEN
TROUTT ANDREW	CAMDEN
TROUTT ANDREW	PARIS
TURNER JOHN W.	MUNFORD
TURNER KELLI A.	NASHVILLE
TURNER WILLIAM C.	CHATTANOOGA
TURNIPSEED DELLWYN M.	MEMPHIS
TURNIPSEED DELLWYN M.	MEMPHIS
TURNIPSEED DELLWYN M.	MEMPHIS
UNDERWOOD THOMAS S.	NASHVILLE
URBANEK ANTHONY	FRANKLIN
VADEN JAMES L.	MEMPHIS
VADEN JAMES L.	COOKEVILLE
VADEN JAMES L.	MEMPHIS
VAUGHAN EDWARD G.	JACKSON
VAUGHAN MICHELLE P.	NASHVILLE
VAZQUEZ ROGER A.	KNOXVILLE
VESTAL REBECCA B.	CHURCH HILL
VESTAL REBECCA B.	JOHNSON CITY
VESTAL REBECCA B.	ROGERSVILLE
VESTAL REBECCA B.	JOHNSON CITY
VESTAL REBECCA B.	ROGERSVILLE
VETTER MICHAEL S.	BRISTOL
WALDON THOMAS G.	NASHVILLE

WALLACE DEBBIE S.	DOVER
WALLACE STEPHEN L.	CLARKSVILLE
WALLS DONNA C.	NASHVILLE
WALTEMATH GARY L.	NASHVILLE
WARD DAVID G.	CLEVELAND
WARREN KARL H.	MIDDLETON
WARRINGTON RICHARD D.	CLARKSVILLE
WATSON WILLIAM A.	MEMPHIS
WATTENBARGER CLYDE K.	SODDY DAISY
WATTS MARY E.	SPRINGFIELD
WATTS MARY E.	SPRINGFIELD
WATTS SAMUEL	MEMPHIS
WEAVER ROBERT M.	CLARKSVILLE
WEEDA, JR. LAWRENCE W.	MEMPHIS
WEISS DANNY	MEMPHIS
WEISS LARRY S.	MEMPHIS
WERTHER JOHN R.	NASHVILLE
WERTHER JOHN R.	NASHVILLE
WETHERINGTON PAMELA	MADISONVILLE
WHEELER JAMES W.	CHATTANOOGA
WHITE CLARICE R.	STANTON
WHITEFIELD MARK H.	HERMITAGE
WHITEHEAD JAMES C.	NASHVILLE
WHITEHEAD JAMES C.	NASHVILLE
WHITEHEAD JAMES C.	NASHVILLE
WHITFIELD ROBERT	PARIS
WHITLEY JEFFREY L.	COVINGTON
WHITWORTH WILLIAM T.	SMITHVILLE
WHITWORTH WILLIAM T.	COOKEVILLE
WHITWORTH WILLIAM T.	CROSSVILLE
WHITWORTH WILLIAM T.	BYRDSTOWN
WHITWORTH WILLIAM T.	LAFAYETTE
WHITWORTH WILLIAM T.	SMITHVILLE
WHITWORTH WILLIAM T.	CROSSVILLE
WHITWORTH WILLIAM T.	CARTHAGE
WHITWORTH WILLIAM T.	SPENCER
WHITWORTH WILLIAM T.	MCMINNVILLE
WHITWORTH WILLIAM T.	WOODBURY
WHITWORTH WILLIAM T.	CELINA
WHITWORTH WILLIAM T.	WOODBURY
WHITWORTH WILLIAM T.	LIVINGSTON
WHITWORTH WILLIAM T.	LAFAYETTE
WHITWORTH WILLIAM T.	CELINA
WHITWORTH WILLIAM T.	SPARTA
WHITWORTH WILLIAM T.	LIVINGSTON
WHITWORTH WILLIAM T.	MCMINNVILLE
WHITWORTH WILLIAM T.	SPENCER
WHITWORTH WILLIAM T.	CARTHAGE
WHITWORTH WILLIAM T.	COOKEVILLE
WHITWORTH WILLIAM T.	BYRDSTOWN
WIDLOSKI MARK M.	KNOXVILLE
WIDLOSKI MARK M.	KNOXVILLE
WIDLOSKI MARK M.	KNOXVILLE
WIDLOSKI MARK M.	KNOXVILLE

WIDLOSKI	MARK M.	KNOXVILLE
WIDLOSKI	MARK M.	OAK RIDGE
WIDLOSKI	MARK M.	KNOXVILLE
WIDLOSKI	MARK M.	LENOIR CITY
WIDLOSKI	MARK M.	MARYVILLE
WIDLOSKI	MARK M.	OAK RIDGE
WIDLOSKI	MARK M.	SEVIERVILLE
WIDLOSKI	MARK M.	LENOIR CITY
WIDLOSKI	MARK M.	ATHENS
WIDLOSKI	MARK M.	ATHENS
WIDLOSKI	MARK M.	SEVIERVILLE
WIGGS	JOSEPH P.	MEMPHIS
WIGGS	JOSEPH P.	MILLINGTON
WIGGS	JOSEPH P.	MILLINGTON
WILHITE JR	ROBERT C.	COLUMBIA
WILHOIT, III	JOHN L.	PIKEVILLE
WILKERSON	STACY R.	SAVANNAH
WILKERSON	STACY R.	SAVANNAH
WILLIAMS	CHADWICK L.	LEBANON
WILLIAMS	CHARLES W.	NASHVILLE
WILLIAMS	J. KENNETH	MADISON
WILLIAMS	MICHEAL A.	MEMPHIS
WILLIAMS	MICHEAL A.	MEMPHIS
WILLIAMS	MICHEAL A.	MEMPHIS
WILLIAMS	VALERIE L.	MADISON
WILLIS	NATHAN D.	BRISTOL
WILSON	DONALD	MCMINNVILLE
WILSON	GREGORY L.	SELMER
WILSON	MARY BETH	WAVERLY
WILSON	MARY BETH	MEMPHIS
WILSON	MARY BETH	CROSSVILLE
WILSON	MARY BETH	COKEVILLE
WILSON	MARY BETH	SHELBYVILLE
WILSON	MARY BETH	COLUMBIA
WILSON	MARY BETH	MCMINNVILLE
WILSON	MARY BETH	KINGSPORT
WILSON	MARY BETH	LYNCHBURG
WILSON	MARY BETH	NOLENSVILLE
WILSON	MARY BETH	COLUMBIA
WILSON	MARY BETH	COKEVILLE
WILSON	MARY BETH	SHELBYVILLE
WILSON	MARY BETH	LYNCHBURG
WILSON	MARY BETH	WAVERLY
WILSON	MARY BETH	KINGSPORT
WILSON	MARY BETH	MEMPHIS
WILSON	MARY BETH	HARTSVILLE
WILSON	MARY BETH	MCMINNVILLE
WILSON	MARY BETH	SPARTA
WILSON	MARY BETH	CROSSVILLE
WILSON	MARY BETH	NOLENSVILLE
WILSON	MARY BETH	ERIN
WILSON	MARY BETH	HARTSVILLE
WILSON	MARY BETH	SPARTA
WILSON	MARY BETH	ERIN

WILSON	O. LEE	KNOXVILLE
WILSON	O. LEE	KNOXVILLE
WILSON	THOMAS	BOLIVAR
WITHERINGTON	TRAVIS A.	OAK RIDGE
WITHERINGTON	TRAVIS A.	POWELL
WITHERINGTON	TRAVIS A.	CROSSVILLE
WITHERINGTON	TRAVIS A.	POWELL
WITHERINGTON	TRAVIS A.	CROSSVILLE
WITT	WAYNE R.	KNOXVILLE
WITT	WAYNE R.	OAK RIDGE
WITT	WAYNE R.	MARYVILLE
WITT	WAYNE R.	OAK RIDGE
WITT	WAYNE R.	SEVIERVILLE
WITT	WAYNE R.	LENOIR CITY
WITT	WAYNE R.	SEVIERVILLE
WITT	WAYNE R.	ATHENS
WITT	WAYNE R.	KNOXVILLE
WITT	WAYNE R.	LENOIR CITY
WITT	WAYNE R.	KNOXVILLE
WITT	WAYNE R.	ATHENS
WITT	WAYNE R.	KNOXVILLE
WITT	WAYNE R.	KNOXVILLE
WITT	WAYNE R.	KNOXVILLE
WOOD	ERIC K.	GOODLETTSVILLE
WOOD, JR.	CLAUDE R.	KNOXVILLE
WOODS	LARRY A.	TULLAHOMA
WOODS	LARRY A.	TULLAHOMA
WOODS	WILLIAM K.	NASHVILLE
WOOLWINE, JR	FRED	CLEVELAND
WOOTEN	MICHAEL D.	KNOXVILLE
WOOTEN	MICHAEL D.	KNOXVILLE
WORTHY	ARTMAS L.	NASHVILLE
WORTHY	ARTMAS L.	NASHVILLE
WORTHY	ARTMAS L.	NASHVILLE
WRIGHT	MELVIN	JACKSON
WRIGHT	RONALD S.	OAK RIDGE
WYATT	DAVID L.	GOODLETSVILLE
WYATT	DAVID L.	GOODLETSVILLE
YALLOURAKIS	STEPHEN J.	KINGSPORT
YARBROUGH	JAY A.	CLARKSVILLE
YATES	MITCHELL E.	CHATTANOOGA
YOUMANS	JAMES	JACKSON
YOUNG	DONALD L.	NASHVILLE
YOUNG	ROGER M.	ARDMORE
YOUNG	RUDY W.	JACKSON
YUILL	ROCHELLE F.	FRANKLIN

ATTACHMENT 3
Co-pay Input File Layout

```
01  WS-INPUT-RECORD.
        05  WS-INPUT-LIKE-FIELDS.
            10  WS-INPUT-SKIP-CONTROL         PIC  X(04).
            10  FILLER REDEFINES WS-INPUT-SKIP-CONTROL.
                15  WS-INPUT-RECORD-TYPE      PIC  X(01).
                15  WS-INPUT-SUBMITTER-ID     PIC  X(03).
                15  FILLER REDEFINES WS-INPUT-SUBMITTER-ID.
                    20  WS-INPUT-ENROLLEES-MCO-ID  PIC  X(03).
        05  WS-INPUT-HT-FIELDS.
            10  WS-INPUT-HT-CREATION-DATE     PIC  9(08).
            10  FILLER REDEFINES WS-INPUT-HT-CREATION-DATE.
                15  WS-INPUT-HT-CDATE-CC      PIC  9(02).
                15  WS-INPUT-HT-CDATE-YY      PIC  9(02).
                15  WS-INPUT-HT-CDATE-MM      PIC  9(02).
                15  WS-INPUT-HT-CDATE-DD      PIC  9(02).
            10  WS-INPUT-HT-RECORD-COUNT      PIC  9(07).
            10  WS-INPUT-HEADER-REST.
                15  WS-INPUT-HEAD-SUBMIT-NO   PIC  X(06).
                15  WS-INPUT-HEAD-FILE-TYPE   PIC  X(01).
                15  FILLER                    PIC  X(101).
            10  WS-INPUT-TRAILER-REST REDEFINES WS-INPUT-HEADER-REST.
                15  WS-INPUT-TRAILER-TOTAL-COPAY  PIC S9(07)V99.
                15  WS-INPUT-TRAILER-SUBMIT-NO    PIC  X(06).
                15  WS-INPUT-TRAILER-FILE-TYPE    PIC  X(01).
                15  FILLER                    PIC  X(92).
        05  WS-INPUT-DETAIL-FIELDS REDEFINES WS-INPUT-HT-FIELDS.
            10  WS-INPUT-DET-SSN              PIC  X(09).
            10  WS-INPUT-DET-LAST-NAME        PIC  X(19).
            10  WS-INPUT-DET-MID-INIT         PIC  X(01).
            10  WS-INPUT-DET-FIRST-NAME       PIC  X(10).
            10  WS-INPUT-DET-DOB              PIC  9(08).
            10  FILLER REDEFINES WS-INPUT-DET-DOB.
                15  WS-INPUT-DET-DOB-CC       PIC  9(02).
                15  WS-INPUT-DET-DOB-YY       PIC  9(02).
                15  WS-INPUT-DET-DOB-MM       PIC  9(02).
                15  WS-INPUT-DET-DOB-DD       PIC  9(02).
            10  WS-INPUT-DET-COPAY            PIC S9(05)V99.
            10  WS-INPUT-DET-DATE-MONTH-MAX   PIC  9(08).
            10  FILLER REDEFINES WS-INPUT-DET-DATE-MONTH-MAX.
                15  WS-INPUT-DET-DT-MONTH-MAX-CC PIC  9(02).
                15  WS-INPUT-DET-DT-MONTH-MAX-YY PIC  9(02).
                15  WS-INPUT-DET-DT-MONTH-MAX-MM PIC  9(02).
                15  WS-INPUT-DET-DT-MONTH-MAX-DD PIC  9(02).
            10  WS-INPUT-DET-DATE-ANN-MAX     PIC  9(08).
            10  FILLER REDEFINES WS-INPUT-DET-DATE-ANN-MAX.
                15  WS-INPUT-DET-DT-ANN-MAX-CC PIC  9(02).
                15  WS-INPUT-DET-DT-ANN-MAX-YY PIC  9(02).
                15  WS-INPUT-DET-DT-ANN-MAX-MM PIC  9(02).
                15  WS-INPUT-DET-DT-ANN-MAX-DD PIC  9(02).
            10  WS-INPUT-DET-DATE-FAM-MAX     PIC  9(08).
            10  FILLER REDEFINES WS-INPUT-DET-DATE-FAM-MAX.
                15  WS-INPUT-DET-DT-FAM-MAX-CC PIC  9(02).
                15  WS-INPUT-DET-DT-FAM-MAX-YY PIC  9(02).
                15  WS-INPUT-DET-DT-FAM-MAX-MM PIC  9(02).
                15  WS-INPUT-DET-DT-FAM-MAX-DD PIC  9(02).
            10  WS-INPUT-DET-TYPE-OF-CLAIM    PIC  X(02).
```

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           10  WS-INPUT-DET-DOS-FROM         PIC  9(08).
           10  FILLER REDEFINES WS-INPUT-DET-DOS-FROM.
              15  WS-INPUT-DET-DOS-FROM-CC   PIC  9(02).
              15  WS-INPUT-DET-DOS-FROM-YY   PIC  9(02).
              15  WS-INPUT-DET-DOS-FROM-MM   PIC  9(02).
              15  WS-INPUT-DET-DOS-FROM-DD   PIC  9(02).
          10  WS-INPUT-DET-DOS-TO          PIC  9(08).
           10  FILLER REDEFINES WS-INPUT-DET-DOS-TO.
              15  WS-INPUT-DET-DOS-TO-CC     PIC  9(02).
              15  WS-INPUT-DET-DOS-TO-YY     PIC  9(02).
              15  WS-INPUT-DET-DOS-TO-MM     PIC  9(02).
              15  WS-INPUT-DET-DOS-TO-DD     PIC  9(02).
           10  WS-INPUT-DET-DATE-PAID       PIC  9(08).
           10  FILLER REDEFINES WS-INPUT-DET-DATE-PAID.
              15  WS-INPUT-DET-DATE-PAID-CC  PIC  9(02).
              15  WS-INPUT-DET-DATE-PAID-YY  PIC  9(02).
              15  WS-INPUT-DET-DATE-PAID-MM  PIC  9(02).
              15  WS-INPUT-DET-DATE-PAID-DD  PIC  9(02).
           10  FILLER                       PIC  X(19).
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The audit output file layout follows:

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       01  WS-AUDITOUT                      PIC  X(132).
       01  WS-AO-LINE1 REDEFINES WS-AUDITOUT.
          05  FILLER                       PIC  X(50).
          05  WS-AO-LINE1-HEADING             PIC  X(32).
          05  FILLER                       PIC  X(30).
          05  WS-AO-LINE1-DATE                PIC  9999/99/99.
          05  FILLER                       PIC  X(10).
       01  WS-AO-LINE2 REDEFINES WS-AUDITOUT.
          05  FILLER                       PIC  X(01).
          05  WS-AO-LINE2-PLAN                PIC  X(08).
          05  WS-AO-LINE2-PLANID              PIC  X(03).
          05  FILLER                       PIC  X(12).
          05  WS-AO-LINE2-FILE                PIC  X(07).
          05  FILLER                       PIC  X(12).
          05  WS-AO-LINE2-ACCEPT-REJECT       PIC  X(08).
          05  FILLER                       PIC  X(81).
       01  WS-AO-LINE-MANY REDEFINES WS-AUDITOUT.
          05  FILLER                       PIC  X(10).
          05  WS-AO-LM-ERROR-CODE             PIC  X(04).
          05  FILLER                       PIC  X(05).
          05  WS-AO-LM-ERROR-DESC             PIC  X(40).
          05  FILLER                       PIC  X(73).
       01  WS-AO-LINE-TOTALS REDEFINES WS-AUDITOUT.
          05  FILLER                       PIC  X(08).
          05  WS-AO-LT-ACCEPTED               PIC  X(24).
          05  WS-AO-LT-ACCEPTED-COUNT         PIC  ZZZZZZZZ9.
          05  FILLER                       PIC  X(07).
          05  WS-AO-LT-REJECTED               PIC  X(24).
          05  WS-AO-LT-REJECTED-COUNT         PIC  ZZZZZZZZ9.
          05  FILLER                       PIC  X(07).
          05  WS-AO-LT-COPAY                  PIC  X(22).
          05  WS-AO-LT-COPAY-AMOUNT           PIC -$,$$$,$$$,$$9.99.
          05  FILLER                       PIC  X(05).
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STATE OF TENNESSEE

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

REQUEST FOR PROPOSALS

FOR

DENTAL BENEFITS MANAGER

RFP NUMBER: 318.65-208

CONTENTS

1 INTRODUCTION

1.1 Statement of Purpose

The State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the State, has issued this Request for Proposals (RFP) to define the State's minimum service requirements; solicit proposals; detail proposal requirements; and, outline the State's process for evaluating proposals and selecting the Contractor.

Through this RFP, the State seeks to buy the best services at the most favorable, competitive prices and to give ALL qualified businesses, including those that are owned by minorities, women, persons with a disability, and small business enterprises, opportunity to do business with the state as Contractors and sub-Contractors.

The State intends to secure a contract for the statewide provision of dental benefits management services for TennCare members under the age of 21. These services, which are more fully described later in the RFP, will include establishment and management of a dental provider network, credentialing and contracting with providers, utilization management and utilization review, provider profiling, ensuring effective dental care within a predictable budget, claims processing, adjudication and payment, management of third party liability, outreach, customer service and interface with the Bureau of TennCare personnel. The contract start date will begin October 1, 2005 with Contractor assuming responsibility for delivering services described in the contract's Section A, Scope of Services, by January 1, 2006.

The Contractor will interface with the TennCare Bureau's Management Information Services system (TCMIS) to provide encounter data and other information to the state (as required) that assures the state's ability to extract data on the delivery of dental services to TennCare members under the age of 21. In addition, at no additional cost to the State, the Contractor must be able to provide ad hoc reports that will assist the Bureau in evaluating the dental benefit. Ad hoc reports will be provided to the TennCare Bureau in a format described by TennCare and on a reasonable timetable. The Contractor may furnish the TennCare Bureau with alternatives to ad hoc reports, such as decision support systems capabilities, that address the managerial concerns of the TennCare Bureau that would normally be requested in an ad hoc report. Purchase and training on such decision support systems would be at no additional cost to the state.

The Contractor's responsibility does not include enrollment of individuals into the TennCare program nor disenrollment from the program. It does, however, include the maintenance of a network of dental providers adequate to meet the service needs of the covered population.

In the performance of the contract, the Contractor will be entrusted with confidential client information. The Contractor shall assure that all material and information, in particular information relating to enrollees or potential enrollees, which is provided to or obtained by or through the Contractor's performance under this Agreement, whether verbal, written, tape or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Agreement.

All information as to personal facts and circumstances concerning enrollees or potential enrollees obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TennCare or the enrollee/potential enrollee, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning enrollee/potential enrollees shall be limited to purposes directly connected with the administration of this Agreement.

Prior to 1994, the State of Tennessee provided a range of dental services to Medicaid eligible individuals. These services were delivered by dental providers contracted directly with the Bureau of Medicaid. Claims for services were submitted directly to the entity under contract as the State's fiscal

intermediary and paid on a pre-determined fee schedule. Payment and remittance advices were forwarded from the fiscal intermediary directly to the providers.

On January 1, 1994, under an 1115 waiver from HCFA (now the Centers for Medicare and Medicaid Services), the State of Tennessee expanded health and dental care coverage beyond the Medicaid eligible population to include previously uninsured and uninsurable individuals. This program is known as TennCare. After closing enrollment to the uninsured in December 1994, the covered population was expanded again in April 1997 to include children under the age of 18 who did not have access to health insurance through a parent or guardian and again in January 1999 to include children under the age of 19 with family incomes below 200% of poverty.

This expanded population was served by a number of Managed Care Organizations contracted with the Bureau of TennCare. These contracts defined the covered services that were to be provided to each member and provided for an all inclusive administrative services fee payment to provide these services. Subcontracts and/or provider agreements with health and dental providers were the responsibility of the MCO(s), as were responsibilities for claims adjudication and payment. Each MCO was contractually required to provide encounter data to the Bureau of TennCare.

As of September 1, 2002, the TennCare population was served by one dental benefits administrator (DBM) contracted with the Bureau of TennCare. This contract defined the covered services that were to be provided to each member and provided for an all inclusive administrative services fee payment for the provision of those services. Subcontracts and/or provider agreements with dental providers were the responsibility of the DBM as were responsibilities for claims adjudication and payment. The DBM was also responsible by contract to provide encounter data, enrollee outreach and other duties.

The Bureau of TennCare is soliciting proposals from Dental Benefit Management Companies. The successful bidder for this contract will be responsible for adhering to all applicable laws, regulations, court orders and policies that govern the administration of a state/federally funded program including the appeals/grievance procedure(s) outlined in A.17 of the pro forma contract (Section 6.1) of this Agreement. This contract will cover dental services for children 0-20. These benefits and definitions are outlined in Section A.1.2 of the pro forma contract.

Current Waiver Information

The structure of the TennCare program at the time of this RFP consists of both traditional Medicaid eligible enrollees (Medicaid and Medically Needy population) and an expanded population of individuals that are non-Medicaid eligible but are either uninsured or uninsurable by the State's current definitions (TennCare Standard). As of May 2005*, the TennCare Medicaid population consists of approximately 592,000 children (0-20). The TennCare Standard population consists of approximately 42,000 children (0-20). Services contracted under this RFP will include both TennCare Medicaid and TennCare Standard .

At this time, Tennessee is preparing changes to TennCare that reduce the size of the population and alter the benefit structure. Changes may be made, based upon input from the legislative review bodies and the federal government. The Contractor should be prepared to deliver services to approximately 634,000 children (age 0-20) by January 2006.

Bidders shall be aware that responding to this RFP will represent the proposer's willingness to administer the current TennCare dental program as well as any modified program resulting from changes in the waiver.

*** The enrollment statistics are based on the Eligibility/Base/Medicare files updated as of May 6, 2005. The eligible counts are based on person's Medicaid ID# and included all recipients with open eligibility segments during May 2005 with MCO assignments on the Eligibility file.**

1.2 Scope of Service, Contract Period, and Required Terms and Conditions

The RFP Attachment 6.1, *Pro Forma* Contract details the State's required:

- Scope of Services and Deliverables in Section A;
- Contract Period in Section B;
- Payment Terms in Section C;
- Standard Terms and Conditions in Section D; and,
- Special Terms and Conditions in Section E.

The *pro forma* contract substantially represents the contract document that the proposer selected by the State MUST agree to and sign.

1.3 Nondiscrimination

No person shall be excluded from participation in, be denied benefits of, be discriminated against in the admission or access to, or be discriminated against in treatment or employment in the State's contracted programs or activities on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal or Tennessee State Constitutional or statutory law; nor shall they be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of contracts with the State or in the employment practices of the State's Contractors. Accordingly, all vendors entering into contracts with the State shall, upon request, be required to show proof of such nondiscrimination and to post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

The State has designated the following to coordinate compliance with the nondiscrimination requirements of the State of Tennessee, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and applicable federal regulations.

Helen Moore
310 Great Circle Road
Nashville, TN 37243

1.4 Assistance to Proposers With a Disability

A Proposer with a disability may receive accommodation regarding the means of communicating this RFP and participating in this RFP process. A Proposer with a disability should contact the RFP Coordinator to request reasonable accommodation no later than the Disability Accommodation Request Deadline detailed in the RFP Section 2, Schedule of Events.

1.5 RFP Communications

1.5.1 **Unauthorized contact regarding this RFP with employees or officials of the State of Tennessee other than the RFP Coordinator detailed below may result in disqualification from this procurement process.**

1.5.1.1 Interested Parties must direct all communications regarding this RFP to the following RFP Coordinator, who is the state of Tennessee's only official point of contact for this RFP.

Alma Chilton
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243
(615) 507-6384 (Phone)
(615) 532-3479 (Fax)
alma.chilton@state.tn.us

1.5.1.2 Notwithstanding the foregoing, Interested Parties may contact the staff of the Governor's Office of Diversity Business Enterprise for general, public information regarding this RFP, assistance available from the Governor's Office of Diversity Business Enterprise, or potential future state procurements.

1.5.2 The State has assigned the following RFP identification number that must be referenced in all communications regarding the RFP:

RFP-318.65-208

1.5.3 Any oral communications shall be considered unofficial and non-binding with regard to this RFP.

1.5.4 Each Proposer shall assume the risk of the method of dispatching any communication or proposal to the State. The State assumes no responsibility for delays or delivery failures resulting from the method of dispatch. Actual or electronic "postmarking" of a communication or proposal to the State by a deadline date shall not substitute for actual receipt of a communication or proposal by the State.

1.5.5 The RFP Coordinator must receive all written comments, including questions and requests for clarification, no later than the Written Comments Deadline detailed in the RFP Section 2, Schedule of Events.

1.5.6 The State reserves the right to determine, at its sole discretion, the appropriate and adequate responses to written comments, questions, and requests for clarification. The State's official responses and other official communications pursuant to this RFP shall constitute an amendment of this RFP.

1.5.7 The State will convey all official responses and communications pursuant to this RFP to the potential proposers from whom the State has received a Notice of Intent to Propose.

1.5.8 Only the State's official, written responses and communications shall be considered binding with regard to this RFP.

1.5.9 The State reserves the right to determine, at its sole discretion, the method of conveying official responses and communications pursuant to this RFP (*e.g.*, written, facsimile, electronic mail, or Internet posting).

1.5.10 Any data or factual information provided by the State, in this RFP or an official response or communication, shall be deemed for informational purposes only, and if a Proposer relies on such data or factual information, the Proposer should either: (1) independently verify the information; or, (2) obtain the State's written consent to rely thereon.

1.6 Notice of Intent to Propose

Each potential proposer should submit a Notice of Intent to Propose to the RFP Coordinator by the deadline detailed in the RFP Section 2, Schedule of Events. The notice should include:

- Proposer's name
- name and title of a contact person
- address, telephone number, and facsimile number of the contact person

NOTICE: A Notice of Intent to Propose creates no obligation and is not a prerequisite for making a proposal, however, it is necessary to ensure receipt of RFP amendments and other communications regarding the RFP (refer to RFP Sections 1.5, *et seq.*, above).

1.7 Proposal Deadline

Proposals must be submitted no later than the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events. A proposal must respond to the written RFP and any RFP exhibits, attachments, or amendments. A late proposal shall not be accepted, and a Proposer's failure to submit a proposal before the deadline shall cause the proposal to be disqualified.

1.8 Pre-Proposal Conference

A Pre-Proposal Conference will be held at the time and date detailed in the RFP Section 2, Schedule of Events. The purpose of the conference is to discuss the RFP scope of services. While questions will be entertained, the response to any question at the Pre-Proposal Conference shall be considered tentative and non-binding with regard to this RFP. Questions concerning the RFP should be submitted in writing prior to the Written Comments Deadline date detailed in the RFP Section 2, Schedule of Events. To ensure accurate, consistent responses to all known potential Proposers, the official response to questions will be issued by the State as described in RFP Sections 1.5, *et seq.*, above and on the date detailed in the RFP Section 2, Schedule of Events.

Pre-Proposal Conference attendance is not mandatory, and each potential Proposer may be limited to a maximum number of attendees depending upon overall attendance and space limitations. The conference will be held at:

310 Great Circle Road
Nashville, Tennessee 37243

1.9. Performance Bond

The State shall require a performance bond upon approval of a contract pursuant to this RFP. The amount of the performance bond must be in the sum of Two Million Dollars ($2,000,000.00). The successful Proposer shall obtain the required performance bond in form and substance acceptable to the State (refer to RFP Attachment 6.6) and provide it to the State no later than the Performance Bond Deadline date detailed in the RFP Section 2, Schedule of Events. Failure to provide the performance bond prior to the deadline as required shall result in contract termination.

In lieu of a performance bond, a surety deposit in the sum of two million dollars ($2,000,000.00) may be substituted if approved by the State prior to its submittal.

2 RFP SCHEDULE OF EVENTS

The following Schedule of Events represents the State's best estimate of the schedule that will be followed. Unless otherwise specified, the time of day for the following events will be between 8:00 a.m. and 4:30 p.m., Central Time.

RFP SCHEDULE OF EVENTS

NOTICE: The State reserves the right, at its sole discretion, to adjust this schedule as it deems necessary. The State will communicate any adjustment to the Schedule of Events to the potential proposers from whom the State has received a Notice of Intent to Propose.

EVENT	TIME	DATE (all dates are state business days)
1. State Issues RFP		**July 15, 2005**
2. Disability Accommodation Request Deadline		**July 22, 2005**
3. Pre-Proposal Conference	**1:00 p.m.**	**July 26, 2005**
4. Notice of Intent to Propose Deadline		**July 29, 2005**
5. Written Comments Deadline		**August 3, 2005**
6. State Responds to Written Comments		**August 15, 2005**
7. Proposal Deadline	**2:00 p.m.**	**August 22, 2005**
8. State Completes Technical Proposal Evaluations		**August 29, 2005**
9. State Opens Cost Proposals and Calculates Scores	**9:00 a.m.**	**August 30, 2005**
10. State Issues Evaluation Notice and Opens RFP Files for Public Inspection	**9:00 a.m.**	**August 31, 2005**
11. Contract Signing		**September 8, 2005**
12. Contract Signature Deadline		**September 15, 2005**
13. Performance Bond Deadline		**September 16, 2005**
14. Contract Start Date (Readiness Review/Transition Begins; Actual Delivery of Services Begin on January 1, 2006)		**October 1, 2005**

15. Readiness Review Begins (Administration and Management, Provider Network Review and Validation, QM Program, Member Services, Benefits, Fee Schedule, Prior Authorization, Information Systems, Encounter Interface, claims processing and payment and other program components)		**October 1, 2005**

3 PROPOSAL REQUIREMENTS

Each Proposer must submit a proposal in response to this RFP with the most favorable terms that the Proposer can offer. There will be no best and final offer procedure.

3.1 Proposal Form and Delivery

3.1.1 Each response to this RFP must consist of a Technical Proposal and a Cost Proposal (as described below).

3.1.2 Each Proposer must submit one (1) original and five (5) copies of the Technical Proposal to the State in a sealed package that is clearly marked:

"Technical Proposal in Response to RFP- 318.65-208 -- Do Not Open"

3.1.3 Each Proposer must submit one (1) Cost Proposal to the State in a separate, sealed package that is clearly marked:

"Cost Proposal in Response to RFP- 318.65-208 -- Do Not Open"

3.1.4 If a Proposer encloses the separately sealed proposals (as detailed above) in a larger package for mailing, the Proposer must clearly mark the outermost package:

"Contains Separately Sealed Technical and Cost Proposals for RFP- 318.65-208"

3.1.5 The State must receive all proposals in response to this RFP, at the following address, no later than the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events.

Alma Chilton
RFP Coordinator
310 Great Circle Road
Nashville, Tennessee 37243

3.1.6 A Proposer may not deliver a proposal orally or by any means of electronic transmission.

3.2 Technical Proposal

3.2.1 The RFP Attachment 6.3, Technical Proposal and Evaluation Guide details specific requirements for making a Technical Proposal in response to this RFP. This guide includes mandatory and general requirements as well as technical queries requiring a written response.

NOTICE: No pricing information shall be included in the Technical Proposal. Inclusion of Cost Proposal amounts in the Technical Proposal shall make the proposal non-responsive and the State shall reject it.

3.2.2 Each Proposer must use the Technical Proposal and Evaluation Guide to organize, reference, and draft the Technical Proposal. Each Proposer should duplicate the Technical Proposal and Evaluation Guide and use it as a table of contents covering the Technical Proposal (adding proposal page numbers as appropriate).

3.2.3 Each proposal should be economically prepared, with emphasis on completeness and clarity of content. A proposal, as well as any reference material presented, must be written in English and must be written on standard 8 1/2" x 11" paper (although foldouts containing charts, spreadsheets, and oversize exhibits are permissible). All proposal pages must be numbered.

3.2.4 All information included in a Technical Proposal should be relevant to a specific requirement detailed in the Technical Proposal and Evaluation Guide. All information must be incorporated into a response

to a specific requirement and clearly referenced. Any information not meeting these criteria will be deemed extraneous and will in no way contribute to the evaluation process.

3.2.5 The State may determine a proposal to be non-responsive and reject it if the Proposer fails to organize and properly reference the Technical Proposal as required by this RFP and the Technical Proposal and Evaluation Guide.

3.2.6 The State may determine a proposal to be non-responsive and reject it if the Technical Proposal document fails to appropriately address/meet all of the requirements detailed in the Technical Proposal and Evaluation Guide.

3.3 Cost Proposal

3.3.1 The Cost Proposal must be submitted to the State in a sealed package separate from the Technical proposal.

3.3.2 Each Cost Proposal must be recorded on an exact duplicate of the RFP Attachment 6.4, Cost Proposal and Evaluation Guide.

3.3.3 Each Proposer shall ONLY record the proposed cost exactly as required by the Cost Proposal and Evaluation Guide and shall NOT record any other rates, amounts, or information.

3.3.4 The proposed cost shall incorporate all costs for services under the contract for the total contract period.

3.3.5 The Proposer must sign and date the Cost Proposal.

3.3.6 If a Proposer fails to submit a Cost Proposal as required, the State shall determine the proposal to be non-responsive and reject it.

4 GENERAL REQUIREMENTS & CONTRACTING INFORMATION

4.1 Proposer Required Review and Waiver of Objections

Each Proposer must carefully review this RFP and all attachments, including but not limited to the *pro forma* contract, for comments, questions, defects, objections, or any other matter requiring clarification or correction (collectively called "comments"). Comments concerning RFP objections must be made in writing and received by the State no later than the Written Comments Deadline detailed in the RFP Section 2, Schedule of Events. This will allow issuance of any necessary amendments and help prevent the opening of defective proposals upon which contract award could not be made.

Protests based on any objection shall be considered waived and invalid if these comments/objections have not been brought to the attention of the State, in writing, by the Written Comments Deadline.

4.2 RFP Amendment and Cancellation

The State reserves the unilateral right to amend this RFP in writing at any time. If an RFP amendment is issued, the State will convey such amendment to the potential proposers who submitted a Notice of Intent to Propose. Each proposal must respond to the final written RFP and any exhibits, attachments, and amendments.

The State of Tennessee reserves the right, at its sole discretion, to cancel and reissue this RFP or to cancel this RFP in its entirety in accordance with applicable laws and regulations.

4.3 Proposal Prohibitions and Right of Rejection

4.3.1 The State of Tennessee reserves the right, at its sole discretion, to reject any and all proposals in accordance with applicable laws and regulations.

4.3.2 Each proposal must comply with all of the terms of this RFP and all applicable State laws and regulations. The State may reject any proposal that does not comply with all of the terms, conditions, and performance requirements of this RFP. The State may consider any proposal that does not meet the requirements of this RFP to be non-responsive, and the State may reject such a proposal.

4.3.3 A proposal of alternate services (*i.e.*, a proposal that offers services different from those requested by this RFP) shall be considered non-responsive and rejected.

4.3.4 A Proposer may not restrict the rights of the State or otherwise qualify a proposal. The State may determine such a proposal to be a non-responsive counteroffer, and the proposal may be rejected.

4.3.5 A Proposer may not submit the Proposer's own contract terms and conditions in a response to this RFP. If a proposal contains such terms and conditions, the State may determine, at its sole discretion, the proposal to be a non-responsive counteroffer, and the proposal may be rejected.

4.3.6 A Proposer shall not submit more than one proposal. Submitting more than one proposal shall result in the disqualification of the Proposer.

4.3.7 A Proposer shall not submit multiple proposals in different forms. This prohibited action shall be defined as a Proposer submitting one proposal as a prime Contractor and permitting a second Proposer to submit another proposal with the first Proposer offered as a subcontractor. This restriction does not prohibit different Proposers from offering the same subcontractors as a part of their proposals, provided that the subcontractor does not also submit a proposal as a prime Contractor. Submitting multiple proposals in different forms may result in the disqualification of all Proposers knowingly involved.

4.3.8 The State shall reject a proposal if the Cost Proposal was not arrived at independently without collusion, consultation, communication, or agreement as to any matter relating to such prices with any

other Proposer. Regardless of the time of detection, the State shall consider any of the foregoing prohibited actions to be grounds for proposal rejection or contract termination.

4.3.9 The State shall not contract with or consider a proposal from:

4.3.9.1 an individual who is, or within the past six months has been, an employee or official of the State of Tennessee;

4.3.9.2 a company, corporation, or any other contracting entity in which an ownership of two percent (2%) or more is held by an individual who is, or within the past six months has been, an employee or official of the State of Tennessee (this shall not apply either to financial interests that have been placed into a "blind trust" arrangement pursuant to which the employee does not have knowledge of the retention or disposition of such interests or to the ownership of publicly traded stocks or bonds where such ownership constitutes less than 2% of the total outstanding amount of the stocks or bonds of the issuing entity);

4.3.9.3 a company, corporation, or any other contracting entity which employs an individual who is, or within the past six months has been, an employee or official of the State of Tennessee in a position that would allow the direct or indirect use or disclosure of information, which was obtained through or in connection with his or her employment and not made available to the general public, for the purpose of furthering the private interest or personal profit of any person; or,

4.3.9.4 any individual, company, or other entity involved in assisting the State in the development, formulation, or drafting of this RFP or its scope of services shall be considered to have been given information that would afford an unfair advantage over other Proposers, and such individual, company, or other entity may not submit a proposal in response to this RFP.

4.3.9.5 For the purposes of applying the requirements of RFP subsection 4.3.9, *et. seq.*, an individual shall be deemed an employee or official of the State of Tennessee until such time as all compensation for salary, termination pay, and annual leave has been paid.

4.3.10 The State reserves the right, at its sole discretion, to waive a proposal's variances from full compliance with this RFP. If the State waives minor variances in a proposal, such waiver shall not modify the RFP requirements or excuse the Proposer from full compliance with such. Notwithstanding any minor variance, the State may hold any Proposer to strict compliance with this RFP.

4.4 Incorrect Proposal Information

If the State determines that a Proposer has provided, for consideration in this RFP process or subsequent contract negotiations, incorrect information that the Proposer knew or should have known was materially incorrect, that proposal shall be determined non-responsive and shall be rejected.

4.5 Proposal of Additional Services

If a proposal offers services in addition to those required by and described in this RFP, the additional services may be added to the contract before contract signing at the sole discretion of the State. Notwithstanding the foregoing, a Proposer shall not propose any additional cost amount(s) or rate(s) for additional services.

NOTICE: The Proposer's Cost Proposal shall record only the proposed cost as required in this RFP and shall not record any other rates, amounts, or information. If a Proposer fails to submit a Cost Proposal as required, the State shall determine the proposal to be non-responsive and shall reject the proposal.

4.6 Assignment and Subcontracting

4.6.1 The Proposer awarded a contract pursuant to this RFP may not subcontract, transfer, or assign any portion of the contract without the State's prior, written approval.

4.6.2 A subcontractor may only be substituted for a proposed subcontractors at the discretion of the State and with the State's prior, written approval.

4.6.3 At its sole discretion, the State reserves the right to refuse approval of any subcontract, transfer, or assignment.

4.6.4 Notwithstanding State approval of each subcontractor, the Proposer, if awarded a contract pursuant to this RFP, shall be the prime Contractor and shall be responsible for all work performed.

4.7 Right to Refuse Personnel

At its sole discretion, the State reserves the right to refuse any personnel, of the prime Contractor or a subcontractor, for use in the performance of a contract pursuant to this RFP.

4.8 Insurance

The State may require the apparent successful Proposer to provide proof of adequate worker's compensation and public liability insurance coverage before entering into a contract. Additionally, the State may require, at its sole discretion, the apparent successful Proposer to provide proof of adequate professional malpractice liability or other forms of insurance. Failure to provide evidence of such insurance coverage is a material breach and grounds for termination of the contract negotiations. Any insurance required by the State shall be in form and substance acceptable to the State.

4.9 Licensure

Before a contract pursuant to this RFP is signed, the apparent successful Proposer must hold all necessary, applicable business and professional licenses. The State may require any or all Proposers to submit evidence of proper licensure.

4.10 Service Location and Work Space

The service pursuant to this RFP is to be performed, completed, managed, and delivered as detailed in the RFP Attachment 6.1, *Pro Forma* Contract. Work space on the State's premises may be available for Contractor use in accordance with the *pro forma* contract or at the State's discretion. Any work performed on the State's premises shall be completed during the State's standard business hours.

4.11 Proposal Withdrawal

A Proposer may withdraw a submitted proposal at any time up to the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events. To do so, a proposer must submit a written request, signed by a Proposer's authorized representative to withdraw a proposal. After withdrawing a previously submitted proposal, a Proposer may submit another proposal at any time up to the Proposal Deadline.

4.12 Proposal Errors and Amendments

Each Proposer is liable for all proposal errors or omissions. A Proposer will not be allowed to alter or amend proposal documents after the Proposal Deadline time and date detailed in the RFP Section 2, Schedule of Events unless such is formally requested, in writing, by the State.

4.13 Proposal Preparation Costs

The State will not pay any costs associated with the preparation, submittal, or presentation of any proposal.

4.14 Disclosure of Proposal Contents

Each proposal and all materials submitted to the State in response to this RFP shall become the property of the State of Tennessee. Selection or rejection of a proposal does not affect this right. All proposal information, including detailed price and cost information, shall be held in confidence during the evaluation process. Notwithstanding, a list of actual proposers submitting timely proposals may be available to the public, upon request, directly after technical proposals are opened by the state.

Upon the completion of the evaluation of proposals, indicated by public release of an Evaluation Notice, the proposals and associated materials shall be open for review by the public in accordance with *Tennessee Code Annotated*, Section 10-7-504(a)(7). By submitting a proposal, the Proposer acknowledges and accepts that the full proposal contents and associated documents shall become open to public inspection.

4.15 Contractor Registration

All service Contractors with state of Tennessee contracts must be registered through the Department of Finance and Administration's Service Provider Registry prior to contract approval. However, registration with the state is not required to make a proposal (any unregistered service provider must simply register as required prior to the final contract approval). Refer to the following Internet URL for more information about the Service Provider Registry and to register "on-line."

www.state.tn.us/finance/rds/ocr/sprs.html

4.16 Contract Approval

The RFP and the Contractor selection processes do not obligate the State and do not create rights, interests, or claims of entitlement in either the Proposer with the apparent best-evaluated proposal or any other Proposer. Contract award and State obligations pursuant thereto shall commence only after the contract is signed by the Contractor and the head of the procuring state agency and after the contract is approved and signed by all other State officials as required by State laws and regulations.

4.17 Contract Payments

All contract payments shall be made in accordance with the contract's Payment Terms and Conditions provisions (refer to RFP Attachment 6.1, *Pro Forma* Contract, Section C). No payment shall be made until the contract is approved as required by State laws and regulations. Under no conditions shall the State be liable for payment of any type associated with the contract or responsible for any work done by the Contractor, even work done in good faith and even if the Contractor is orally directed to proceed with the delivery of services, if it occurs before contract approval by State officials as required by applicable statutes and rules of the State of Tennessee or before the contract start date or after the contract end date specified by the contract.

4.18 Contractor Performance

The Contractor shall be responsible for the completion of all work set out in the contract. All work is subject to inspection, evaluation, and acceptance by the State. The State may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the contract. At reasonable times, the State may inspect those areas of the Contractor's place of business that are related to the performance of the contract. If the State requires such an inspection, the Contractor shall provide reasonable access and assistance.

4.19 Contract Amendment

During the course of this contract, the State may request the Contractor to perform additional work for which the Contractor would be compensated. That work shall be within the general scope of this RFP.

In such instances, the State shall provide the Contractor a written description of the additional work, and the Contractor shall submit a time schedule for accomplishing the additional work and a price for the additional work based on the rates included in the Contractor's proposal to this RFP. If the State and the Contractor reach an agreement regarding the work and associated compensation, such agreement shall be effected by means of a contract amendment. Any such amendment requiring additional work must be mutually agreed upon by the parties and signed by the Contractor and the head of the procuring state agency and must be approved by other State officials as required by State laws and regulations. The Contractor shall not commence additional work until the State has issued a written contract amendment and secured all required approvals.

4.20 Severability

If any provision of this RFP is declared by a court to be illegal or in conflict with any law, said decision shall not affect the validity of the remaining RFP terms and provisions, and the rights and obligations of the State and Proposers shall be construed and enforced as if the RFP did not contain the particular provision held to be invalid.

5 PROPOSAL EVALUATION & CONTRACT AWARD

5.1 Evaluation Categories and Maximum Points

The State will consider qualifications and experience, technical approach, and cost in the evaluation of proposals. The maximum points that shall be awarded for each of these categories are detailed below.

CATEGORY	MAXIMUM POINTS POSSIBLE
Qualifications and Experience	**30**
Technical Approach	**40**
Cost Proposal	**30**

5.2 Evaluation Process

The proposal evaluation process is designed to award the contract not necessarily to the Proposer of least cost, but rather to the Proposer with the best combination of attributes based upon the evaluation criteria.

5.2.1 The RFP Coordinator will use the RFP Attachment 6.3, Technical Proposal and Evaluation Guide to manage the Technical Proposal Evaluation and maintain evaluation records.

5.2.1.1 The RFP Coordinator will review each Technical Proposal to determine compliance with mandatory requirements (refer to RFP Attachment 6.3, Technical Proposal and Evaluation Guide, Technical Proposal Section A). If the RFP Coordinator determines that a proposal may have failed to meet one or more of the mandatory requirements, the Proposal Evaluation Team will review the proposal and document its determination of whether: (1) the proposal meets requirements for further evaluation; (2) the State will request clarifications or corrections; or, (3) the State will determine the proposal non-responsive to the RFP and reject it.

5.2.1.2 A Proposal Evaluation Team, made up of three or more State employees, will evaluate each Technical Proposal that appears responsive to the RFP.

5.2.1.3 Each Proposal Evaluation Team member will independently, evaluate each proposal against the evaluation criteria in this RFP, rather than against other proposals, and will score each in accordance with the RFP Attachment 6.3, Technical Proposal and Evaluation Guide.

5.2.1.4 The State reserves the right, at its sole discretion, to request Proposer clarification of a Technical Proposal or to conduct clarification discussions with any or all Proposers. Any such clarification or discussion shall be limited to specific sections of the proposal identified by the State. The subject Proposer shall put any resulting clarification in writing as may be required by the State.

5.2.2 After Technical Proposal evaluations are completed, the RFP Coordinator will open the Cost Proposals and use the RFP Attachment 6.4, Cost Proposal and Evaluation Guide to calculate and document the Cost Proposal scores.

5.2.3 For each responsive proposal, the RFP Coordinator will add the average Technical Proposal score to the Cost Proposal score (refer to RFP Attachment 6.5, Proposal Score Summary Matrix).

5.3 Contract Award Process

5.3.1 The RFP Coordinator will forward the results of the proposal evaluation process to the head of the procuring agency who will consider the proposal evaluation process results and all pertinent

information available to make a determination about the contract award. The State reserves the right to make an award without further discussion of any proposal.

Notwithstanding the foregoing, to effect a contract award to a proposer other than the one receiving the highest evaluation score, the head of the procuring agency must provide written justification for such an award and obtain the written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury.

5.3.2 After the agency head's determination, the State will issue an Evaluation Notice to identify the apparent best-evaluated proposal on the Evaluation Notice date detailed in the RFP Section 2, Schedule of Events.

NOTICE: The Evaluation Notice shall not create rights, interests, or claims of entitlement in either the Proposer with apparent best-evaluated proposal or any other Proposer.

5.3.3 The State will also make the RFP files available for public inspection on the Evaluation Notice date detailed in the RFP Section 2, Schedule of Events.

5.3.4 The Proposer with the apparent best-evaluated proposal must agree to and sign a contract with the State which shall be substantially the same as the RFP Attachment 6.1, *Pro Forma* Contract.

However, the State reserves the right, at its sole discretion, to add terms and conditions or to revise *pro forma* contract requirements in the State's best interests subsequent to this RFP process. No such terms and conditions or revision of contract requirements shall materially affect the basis of proposal evaluations or negatively impact the competitive nature of the RFP process.

5.3.5 The Proposer with the apparent best-evaluated proposal must sign and return the contract drawn by the State pursuant to this RFP no later than the Contract Signature Deadline date detailed in the RFP Section 2, Schedule of Events. If the Proposer fails to provide the signed contract by the deadline, the State may determine that the Proposer is non-responsive to the terms of this RFP and reject the proposal.

5.3.6 If the State determines that the apparent best-evaluated proposal is non-responsive and rejects the proposal after opening Cost Proposals, the RFP Coordinator will re-calculate scores for each responsive Cost Proposal to determine the new, apparent best-evaluated proposal.

ATTACHMENT 6.1

PRO FORMA CONTRACT

The *pro forma* contract detailed in this attachment contains some "blanks" (signified by descriptions in capital letters) that will be completed with appropriate information in the final contract resulting from this RFP.

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
AND

This Contract, by and between the State of Tennessee, Department of Finance and Administration, Bureau of TennCare, hereinafter referred to as the "State" and [CONTRACTOR LEGAL ENTITY NAME], hereinafter referred to as the "Contractor," or "DBM" (Dental Benefits Manager), is for the provision of dental administrative and management services as further defined in the "SCOPE OF SERVICES."

The Contractor is [AN INDIVIDUAL / A FOR-PROFIT CORPORATION / A NONPROFIT CORPORATION / A SPECIAL PURPOSE CORPORATION OR ASSOCIATION / A FRATERNAL OR PATRIOTIC ORGANIZATION / A PARTNERSHIP / A JOINT VENTURE / A LIMITED LIABILITY COMPANY]. The Contractor's address is:

[ADDRESS]

The Contractor's place of incorporation or organization is [STATE OF ORGANIZATION].

The Contractor is a corporation which has qualified as an Administrator (aka "Third Party Administrator") in compliance with Tennessee Code Annotated Section 56-6-401 et seq. and is licensed to operate as an adjustor or settler of claims in connection with dental insurance benefits coverage in the State of Tennessee and is capable of providing or arranging for health care services provided to covered persons for whom it receives payment and is engaged in said business and is willing to do so upon and subject to the terms and conditions hereof.

A. SCOPE OF SERVICES

The Contractor agrees to administer the TennCare dental benefit as specified in this Agreement. The Contractor shall make maximum efforts to ensure minimum disruption in service to members and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the Agreement.

A.1. OBLIGATIONS OF THE Contractor

A.1.1. Services. The Contractor will manage the program in a manner that ensures an adequate network of qualified dental providers for whom the Contractor is responsible. These providers will render high quality, medically necessary, cost effective dental care. Furthermore, the Contractor will exercise every available means through this contract, provider agreement, office reference manual or Contractor's policies and procedures to ensure that the program is managed in this manner.

A.1.2. Benefit Packages. The Contractor will be responsible for ensuring that the following is provided:

A.1.2.1. Under Age 21, Preventive, diagnostic and treatment services. Any limitations described in this Agreement, including Attachment I, shall be exceeded to the extent that it is necessary in accordance with EPSDT requirements. At any time, by amendment to this contract, TennCare may alter the covered benefits for the TennCare Standard members under 21.

A.1.2.2. Orthodontics. Orthodontic services are limited to eligible individuals under age 21. There must be authorization for treatment and the treatment must have begun at least six (6) months prior to the enrollee's 21st birthday. Approved treatment begun at least six (6) months prior to the enrollee's 21st birthday may continue past age 21 as long as the individual remains eligible. Orthodontic services are limited to individuals diagnosed with (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, ascertained by using the Salzmann Malocclusion Severity Index, or any other method that is approved by TennCare, or (2) following the repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes.

A.1.3. Enrollee Cost Share Responsibilities. The Contractor and all providers and subcontractors shall not require any cost sharing responsibilities for TennCare covered services except to the extent that cost sharing responsibilities are required for those services by TennCare in accordance with TennCare rules and regulations or TennCare approved policies and procedures for TennCare enrollees, nor may the Contractor and all providers and subcontractors charge enrollees for missed appointments. Enrollees may not be held liable for payments in the event of the Contractor's insolvency. Enrollees may not be held liable for payments in the event the State does not pay the Contractor, or the Contractor does not pay the provider. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e. no balance billing by providers.)

Cost sharing responsibilities shall apply to services other than the preventive services described in Section A.1.2.1 and specified in the table below. Co-payments shall be applied on a sliding scale according to the enrollee's income. The maximum out-of-pocket expenses an enrollee may incur as the result of cost sharing responsibilities shall also be limited according to the enrollee's income. The procedure code listing for preventive services is as follows:

Preventive Dental Services for Children Under 21 Years of Age

D1110	Prophylaxis (when billed for children over age 12 and under age 21)
D1120	Prophylaxis
D1201	Topical Application of Fluoride (Prophylaxis included) - child
D1203	Topical Application of Fluoride (Prophylaxis not included) - child
D1310	Nutritional Counseling for Control of Dental Disease
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease
D1330	Oral Hygiene Instructions
D1351	Sealant per Tooth

The current sliding scale schedule to be used in determining applicable cost sharing responsibilities and out-of-pocket expenses for TennCare enrollees is described in the chart below.

Co-Pay	0 to 100% of Poverty	101-199% of Poverty	200% and Above Poverty
Dental visits	0	$15 per visit	$25 per visit
Annual out-of-pocket maximum (includes all TennCare covered copay services)	N/A	$1,000 for individuals;	$2,000 for individuals; $4,000 for families

		$2,000 for families	

The Contractor shall track and report to TennCare the amount of enrollee cost-sharing liabilities on a quarterly basis in a form and format to be specified by TennCare. TennCare shall aggregate cost-sharing information submitted by TennCare DBM, MCOs, BHOs and the PBM to identify enrollees that have met or exceeded their annual out-of-pocket expenditure maximum. The Contractor agrees to coordinate reimbursement to enrollees, either directly or through its network providers, that have exceeded the applicable out-of-pocket maximum, upon receipt of notification by TennCare. Should the Contractor elect to reimburse enrollees through its network providers, the Contractor shall conduct an audit of the providers that have been reimbursed in order to assure that enrollees received appropriate credit and/or reimbursement and are held harmless for amounts that exceed their out-of-pocket maximum.

The Contractor shall be expressly prohibited from waiving or using any alternative cost sharing schedules, unless required by TennCare. Further, the Contractor shall not discourage enrollees from paying applicable co-payment obligations.

If, and at such time that changes occur to the cost sharing rules, the contractor will be notified of new co-payment rates.

The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus any applicable amount of cost sharing responsibilities due from the enrollee as payment in full for the service. Should a provider, or a collection agency acting on the provider's behalf, bill an enrollee for amounts other than the applicable amount of cost sharing responsibilities due from the enrollee, once a Contractor becomes aware the Contractor shall notify the provider and demand that the provider and/or collection agency cease such action against the enrollee immediately. After notification by the Contractor, if a provider continues to bill an enrollee, the Contractor shall refer the provider to the TBI.

Providers or collection agencies acting on the provider's behalf may not bill enrollees for amounts other than applicable cost sharing responsibilities for TennCare covered services except as permitted by TennCare rule 1200-13-13-.08 and as described below. Providers may seek payment from an enrollee in the following situations:

1. if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service. The provider is required to inform the enrollee of the non-covered service and have the enrollee acknowledge the information. If the enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills the DBM for the service that has been provided, the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

2. if the enrollee's TennCare eligibility is pending at the time services are provided and if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the enrollee about private payment, once the provider bills the DBM for the service the prior arrangement with the enrollee becomes null and void without regard to any prior arrangement worked out with the enrollee; or

3. if the enrollee's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable cost share amounts must be refunded when a claim is submitted to the DBM if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); or

A.1.4. Adherence to TennCare Rules and Regulations: The Contractor shall perform all services under this Agreement. Contractor shall comply with all applicable administrative rules and TennCare written policies and procedures, as may be amended from time to time. TennCare shall provide Contractor with copies of such rules and policies.

A.1.5. The CONRACTOR shall demonstrate to TennCare progressively significant increases in the percentage of children being screened toward the achievement of a screening percentage of 80%.

A.2 EVIDENCE OF ENROLLEE COVERAGE AND ENROLLEE MATERIAL

A.2.1. Enrollee Materials. The Contractor shall distribute various types of enrollee materials as required in this Agreement. Specific information regarding these materials, the Member Handbook, Quarterly Newsletter and other items are outlined in Attachment II. Permissible and prohibited communication activities, enrollee and written materials guidelines are defined in Attachment II.

A.2.2. Failure to Comply with Enrollee Material Requirements. All services listed in A.1.2 must be provided as described and the materials must adhere to the requirements as described and must not mislead, confuse, or defraud the recipients or the State Agency. Failure to comply with the communication limitations contained in this Agreement, including but not limited to the use of unapproved and/or disapproved communication material, may result in the imposition by TennCare of one or more sanctions as provided in Section E.4 and Attachment I of this agreement.

A.2.3. Prohibited Communication Activities: The following information and activities are prohibited:

A.2.3.1. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers. Further, the Contractor shall adhere to requirements for the written materials to assure that material is accurate and does not mislead, confuse or defraud the recipients or the state agency and materials shall be subject to review by TennCare.

A.2.3.2. There shall be no soliciting of enrollees;

A.2.4. The Contractor shall be responsible for postage on all mailings sent out by the Contractor.

A.3 STAFFING REQUIREMENTS

A.3.1 Office Location. Contractor must maintain a physical office in Metropolitan-Davidson County, Tennessee, or counties contiguous to Metropolitan-Davidson County. Staff specified in Section A.3.2.b shall be physically located in that office unless otherwise agreed to by TennCare.

A.3.2 Staffing Plan

A.3.2.a The Contractor shall not have an employment, consulting or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with the State.

A.3.2.b The administrative staffing for the plan covered by this Agreement must be capable of fulfilling the requirements of this Agreement and is in addition to contracted dental providers rendering clinical services. A single individual may hold more than one (1) position unless otherwise specified. The minimum staff requirements are as follows:

1. A full-time administrator (project director) specifically identified with overall responsibility for the administration of this Agreement. This person shall be at the Contractor's officer level and must be approved by the State. Said designee shall be responsible for the coordination and operation of all aspects of the Agreement;

2. Sufficient full-time support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, prior authorizations, appeal system resolution, and claims processing and reporting, as determined through management and medical reviews;

3. A full-time EPSDT Outreach Coordinator whose primary duties include development and implementation of the Contractor's strategy to increase EPSDT screening rates;

4. A dentist who is licensed by and physically located in the State of Tennessee to serve as dental director to oversee and be responsible for the proper provision of covered services to members;

5. A staff of qualified, medically trained personnel, whose primary duties are to assist in evaluating medical necessity;

6. A person who is trained and experienced in information systems, data processing and data reporting as required to provide necessary and timely reports to TennCare;

7. The Contractor shall appoint a staff person as its Non-discrimination Compliance Coordinator to be responsible for compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Reconciliation Act of 1981 (P.E. 97-35) on behalf of the Contractor. The Contractor does not have to require that compliance with the aforementioned federal and state regulations be the sole function of the designated staff member. However, the Contractor shall identify the designated compliance staff member to TennCare by name. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported in writing to TennCare within ten (10) calendar days of the change.

8. The Contractor shall appoint a staff person to be responsible for communicating with TennCare regarding member service issues.

9. The Contractor shall appoint a staff person to be responsible for communicating with TennCare regarding provider service issues. Further, the Contractor shall have a provider service line staffed adequately to respond to providers' questions during normal business hours, including appropriate and timely responses regarding prior authorization requests as described in this Agreement. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the TennCare program, including but not limited to EPSDT. The Contractor shall adequately staff the provider service line to assure that the average wait time for assistance does not exceed 10 minutes.

10. The Contractor shall appoint Care Coordinators and Claim Coordinators in order to coordinate and resolve issues related to MCO/DBM coordination issues as described in Section A.8 of this Agreement. Further, the Contractor shall appoint a Care Coordination Committee and a Claims Coordination Committee made up of the Care/Claim Coordinators and other staff as appropriate. A list with the names and phone numbers of said representatives shall be provided by the DBM to the MCO and TennCare.

11. The Contractor shall provide a twenty-four (24) hour toll-free telephone line accessible to enrollees that provides information to enrollees about how to access needed services. In addition, the Contractor shall appoint and identify in writing to TennCare a responsible contact available after hours for the "on-call" TennCare Solutions staff and enrollees to contact with service issues.

12. The Contractor shall identify in writing the name and contact information for the Project Director, Dental Director, EPSDT Outreach Coordinator, and the Non-discrimination Compliance Coordinator. Key contact persons shall also be provided for Accounting and Finance, Prior Authorizations, Claims Processing, Information Systems, Member Services, Provider Services, Appeal System Resolution, within thirty (30) days of Agreement execution. Any changes in staff

persons during the term of this Agreement must be made in writing within 10 business days. The identity of each of the persons listed above shall be disclosed on the Contractor's web site.

The Contractor's failure to comply with staffing requirements as described in this agreement shall result in the application of intermediate sanctions and liquidated damages as specified in Section E.4 and Attachment I of this Agreement.

A.3.4. Licensure. The Contractor is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of $250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and TennCare may terminate this Agreement for cause as described in Section D.4. of this Agreement.

A.4. ACCESS AND AVAILABILITY TO CARE

The Contractor must arrange for the provision of all services described as covered in this Agreement. The Contractor shall maintain under contract, a state-wide provider network, including General Dentists and Dental Specialists, adequate to make services, service locations, and service sites available and accessible in accordance with the Terms and Conditions for Access and Availability of the TennCare Waiver and as contained herein. Nothing in this Agreement shall be construed to preclude the Contractor from closing portions of the network to new providers when all conditions of access and availability are met (see Paragraph A.4.1. and A.18.5)

A.4.1 Access to Care. The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept new TennCare enrollees within each geographical location in the state so that appointment waiting times do not exceed 3 weeks for regular appointments and 48 hours for urgent care. The Contractor must consider the following:

a. The anticipated Medicaid enrollment
b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the DBM
c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services
d. The numbers of network providers who are not accepting new Medicaid patients
e. The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

The Contractor must ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Services must be available 24 hours a day, 7 days a week, when medically necessary.

A.4.2. Transport Time. The Contractor shall maintain under contract a network of dental providers to provide the covered services specified in A.1.2. statewide. The Contractor shall make services, service locations and service sites available and accessible so that transport time to dental providers will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards, as defined by TennCare. Exceptions must be justified and documented to the State on the basis of community standards.

A.4.3 Office Wait Time. Office waiting time shall not exceed 45 minutes.

A.4.4. Provider Choice. Each enrollee shall be permitted to obtain covered services from any general or pediatric dentist in the Contractor's network accepting new patients.

A.4.5. Out of Network Providers. If the Contractor's network is unable to provide necessary, medical services covered under the contract to a particular enrollee, the Contractor must adequately and timely cover

these services out of network for the enrollee, for as long as the Contractor is unable to provide them. Out of network providers must coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the enrollee is no greater than in would be if the services were furnished within the network.

A.4.6 The Contractor must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

A.5. PROVIDER NETWORK REQUIREMENTS

A.5.1 The Contractor is encouraged to contract for the provision of services with Federally Qualified Health Clinics (FQHCs), FQHC look-alikes, metropolitan or county Health Departments, University affiliated dental programs and may, at the discretion of TennCare, be required to secure such contracts. In addition, where FQHCs with the capacity to deliver dental services are not utilized, the Contractor must demonstrate that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected needs in a service area without contracting with FQHCs.

If the Contractor utilizes FQHCs for services, the Contractor is required to address cost issues related to the scope of services provided by FQHCs and shall reimburse FQHCs on a cost related basis.

A.5.2 The Contractor must submit documentation assuring adequate network capacity and services as specified by the State.

A.6 MEMBER SERVICES

A.6.1. Members Services Hotline. Contractor shall provide a toll-free telephone service for all regular business days Monday through Friday. Since Tennessee spans two time zones, this service shall be operated from 7:00 a.m. Central Standard Time to 5:00 p.m. Central Standard Time and corresponding hours during periods of Daylight Savings Time. The member service lines shall be adequately staffed and individual staff trained to accurately respond to questions regarding covered services, to assist enrollees locate a participating dental provider, and other issues, including but not limited to EPSDT.

A.6.2. Translation Services. In addition to the toll-free telephone number, Contractor shall provide language translation services, either directly or by contracting with a service such as AT&T's Language Line (See Attachment III specifying Non-discrimination Compliance requirements).

A.6.3. TDD/TDY. The Contractor shall make TDD/TDY services available to members.

A.6.4 Appointment Assistance. The Contractor will assist members in obtaining appointments for covered services, including facilitation of member contact with a Participating Dental Provider who will establish an appointment. The Contractor shall track the number of requests for assistance to obtain an appointment, including the service area in which the enrollee required assistance.

A.6.5. Provider Listing. The Contractor shall provide all enrollees (or heads of households), with a provider listing within thirty (30) days of initial enrollment, and upon request, such list shall include current provider address(es), telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. This list shall be updated no less frequently than quarterly. All provider directories shall be approved by TennCare prior to the Contractor's distribution.

A.6.6 I.D. Card. The Contractor shall not be required to provide identification cards to TennCare enrollees; however, the Contractor shall provide TennCare with a written process detailing how members and providers will access information, including but not limited to, pertinent phone numbers for member services, provider identification of eligible individuals and access to prior authorization procedures, etc.

A.7 UTILIZATION MANAGEMENT

A.7.1. Policies and Procedures. The Contractor shall provide an electronic and two written copies of its dental management policies and procedures to TennCare for approval.

A.7.2. Prior Approvals. Said policies and procedures must clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of a service. TennCare shall have thirty (30) days to review and approve or request modifications to the policies and procedures. Should TennCare not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the State from requiring the Contractor to respond or modify the policy or operating guideline prospectively. Dental management policies and procedures must be consistent with the following requirements:

a. Requests for prior approvals that are denied by the Contractor must be denied in writing within 14 days of receipt.

b. Prior approval shall not be required for referrals from the Public Health Screening Program, Primary Care Physicians, and for preventive services as defined in A.1.2 and A.1.3.

c. Utilization management activities may not be structured so as to provide incentives for the individual or Contractor to deny, limit, or discontinue medically necessary services to any enrollee.

A.7.3. Retrospective Utilization Review. The Contractor will conduct retrospective treatment utilization review. This review will evaluate the dental provider's treatment practice within a network of individual providers performing similar processes and identify those whose treatment utilization pattern deviates from their peer's norm. The process will incorporate basic provider profiling, test edits, and statistical process controls (SPC). SPC is a methodology of evaluating normal statistical variability or "noise" within any type of process. Normally the statistical limits are set at ± three standard deviations so that any determination outside of these upper and lower control limits is expected to be a significant deviation from the network group being measured. If the type of finding elicited in the retrospective treatment utilization review process necessitates chart audit of a dental provider, the Contractor is expected to perform a chart audit.

The Contractor is required by this Agreement to maintain a Peer Review Committee made up of licensed Tennessee dentists in good standing in the state (See paragraph A.18.3). This committee will review the case files generated by the utilization review process. After the Tennessee Peer Review Committee has completed its review and established its findings and recommendations, these are then forwarded back to the Contractor for formal action. The Contractor will forward to the TennCare Dental Director and Office of Inspector General's Program Integrity Unit, a monthly audit update including a summary of its investigation and actions taken.

The Contractor's utilization review process intervention includes various options that safeguard children, improve quality of care, assure fiscal viability of the program and comport with TennCare's mission. These options include issuance of corrective action plans, provider education, recoupment of provider payments or any combination of these actions. Additionally, in accordance with its Provider Service Agreement, the Contractor may also choose to exercise its prerogative to terminate a dental provider with or without cause with thirty days notice.

A.7.4 Urgent Care. Contractor shall ensure access to services for urgent dental and oral conditions or injuries on the basis of the professional judgment of the enrollee's treating dentist, other dental professional, primary care provider or a triage nurse who is trained in dental care and oral health care.

A.7.4.1. The Contractor may not deny payment for treatment obtained when a representative of the Contractor instructs the eligible enrollee (ages 0–20) to seek emergency services and must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the Contractor. Under the terms of this Agreement and the TennCare MCO Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

A.7.4.2. The Contractor may not deny payment for treatment obtained when an eligible enrollee (ages 0-20) had an emergency medical condition, where it is the Contractor's responsibility to pay, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical conditions. Under the terms of this Agreement and the TennCare MCO Agreement, the MCO is responsible for the provision of treatment for emergency medical conditions and is also responsible for the facilities and physician charges for dental services provided in a hospital emergency room.

A.7.5 Continuity of Care. The Contractor shall accept claims and authorize reimbursement for Covered Services that were approved or were part of a course of treatment that started prior to the Effective Date of this Agreement.

A.7.6. Referral Requirements. A patient must be referred by a general dentist or pediatric dentist to a dental specialist (e.g., oral surgeon, endodontist, orthodontist) for the initial visit for services requiring specialized expertise. Subsequent visits to the same specialist in a course of treatment do not require separate referrals. The Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee. Additionally, The Contractor must have a mechanism in place to allow special needs enrollees and enrollees determined to require an ongoing course of treatment direct access to specialists as appropriate.

A.8 CARE COORDINATION

A.8.1 Transition Period. In the event a TennCare enrollee is receiving medically necessary covered dental services the day before the effective date of this Agreement, the Contractor shall authorize the continuation of said services without any form or prior approval and regardless of whether the services are being provided by a provider within or outside the Contractor's provider network.

In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the previous DBM and/or TennCare as directed to identify enrollees for whom prior approvals were issued prior to the effective date of this Agreement. To the extent that the approvals are for covered services and are within the parameters of the TennCare approved policies and procedures for prior approvals as outlined in Section A.7.2 of this Agreement, Contractor will accept and honor those prior approvals for the first ninety days of this Agreement.

A.8.2 Transition Management. The Contractor shall coordinate with the previous DBM so that dental inquiries received after January 1, 2006 are redirected to the Contractor.

A.8.3 Coordination Between MCO and Contractor (DBM). The provision of Dental services are the responsibility of the Contractor, however, the provision of transportation to and from said services as well as the medical and anesthesia services related to the dental service (with the exception of anesthesia services administered by a dental provider or in a dentist office) shall remain with the MCO. The Contractor shall remain responsible for anesthesia services that are appropriately provided by a dental provider or in a dentist's office. The Contractor shall agree to coordinate dental and medical services in accordance with the following provisions.

The Contractor shall be responsible for: (1) authorizing dental services for which they have the responsibility to pay; and (2) arranging services that are not covered under this Agreement to be provided, when appropriate, with providers that are contracted in the MCO's plan. The MCO shall be responsible for authorizing said services that require transportation, anesthesia (with the exception of anesthesia services administered by a dental provider or in a dentist office), and/or medical services related to the dental service; however, the MCO may waive authorization of said services based on authorization of the dental services by the Contractor. The Contractor and the MCO may develop policies and procedures to further clarify responsibilities of the DBM and the MCO. TennCare will work to facilitate implementation of said policies and procedures.

A.8.3.1 Services and Responsibilities

Coordination of dental services, at a minimum, include:

- Means for referral which assures immediate access for emergency care and a provision of urgent and routine care according to TennCare guidelines;
- Means for the transfer of information (to include items before and after the visit);
- Maintenance of confidentiality;
- Cooperation with the MCO regarding training activities provided by the MCO.
- Results of any identification and assessment of any enrollee with special health care needs (as defined by the State) so that those activities need not be duplicated;
- Mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.
- If applicable, the development of treatment plans for enrollees with special health care needs that are developed by the enrollee's primary care provider with enrollee participation and in consultation with any specialists caring for the enrollee. These treatment plans must be approved by the Contractor in a timely manner, if approval is required, and be in accord with any applicable State quality assurance and utilization review standards.

A.8.3.2 Operating Principles

Coordinating the delivery of dental services to TennCare members is the primary responsibility of the Contractor. To ensure such coordination, the Contractor shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with that coordinator. The Contractor shall be responsible for communicating the MCO provider services and/or claim coordinator contact information to all of its providers. With respect to specific member services, resolution of problems shall be carried out between the MCO coordinator and the DBM coordinator. Should systemic issues arise, the MCO and the Contractor agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the Contractor shall meet with TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within ninety (90) days from referral to TennCare.

A.8.3.2.1. Resolution of Requests for Authorization. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, that any dispute concerning which party should respond to a request for prior authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate service to a TennCare member. DBM and MCO agree that Care Coordinators will, in addition to their responsibilities for care coordination, deal with issues related to requests for authorization which require coordination between DBM and MCO. The DBM and MCO shall provide the other party with a list of its Care Coordinators and telephone number(s) at which each Care Coordinator may be contacted. When either party receives a request for authorization from a provider for a member and the party believes care is the responsibility of the other party, the Care Coordinator for that party will contact the respective Care Coordinator of the other party by the next business day after receiving the request for prior authorization and communicate to the enrollee or enrollee's provider for routine requests which shall be made within 14 days or less of the provider's request for prior authorization and immediately after receiving the request for prior authorization for urgent requests. The DBM and MCO will establish a coordination committee to address all issues of care coordination. The committee will review disputes regarding clinical care and provide a clinical resolution to the dispute, subject to the terms of this Agreement. The parties will attempt in good faith to resolve any dispute and communicate the decision to the provider requesting authorization of a service. In the event the parties cannot agree within 15 days of the provider's request for prior authorization, the party who first received the request from the provider will be responsible for authorization and payment to their contracted provider within the time frames designated by the

Bureau of TennCare. Both parties are responsible for enforcing hold harmless protection for the member. The parties agree that any response to a request for authorization shall not exceed 14 days and shall comply with the *Grier* Revised Consent Decree (modified) (www.tnjustice.org).

A.8.3.2.2 Claim Resolution Authorization. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, to designate one or more Claim Coordinators to deal with issues related to claims and payment issues that require coordination between DBM and MCO (parties). The DBM and MCO shall provide the other party, and TennCare with a list of its Claim Coordinators and telephone number(s) at which each Claim Coordinator may be contacted.

When either party receives a disputed claim for payment from a provider for a member and the party believes care is the responsibility of the other party, the Claims Coordinator for that party will contact the respective Claims Coordinator of the other party within four (4) business days of receiving such claim for payment. If the Claims Coordinators are unable to reach agreement on which party is responsible for payment of the claim, the claim shall be referred to the Claims Coordination Committee for review.

The DBM and MCO will establish a Claim Coordination Committee made up of Claims Coordinators and other representatives, as needed, from each party. The number of members serving on the Claim Coordination Committee shall be determined by the mutual agreement of the parties from time to time during the term of this Agreement, or, if the parties fail to agree within ten (10) calendar days of the execution of this Agreement, the Claim Coordination Committee shall consist of two (2) representatives of each party. The Claim Coordination Committee shall review any disputes and negotiate responsibility among the parties. Unless otherwise agreed, such meeting shall take place within ten (10) calendar days of receipt of the initial disputed claim or request from the provider. If resolution of the claim results in the party who assumed responsibility for authorization and payment having no liability, the other party will reimburse and abide by the prior decisions of that party. Reimbursement will be made within ten (10) business days of the Claim Coordination Committee's decision.

If the Claim Coordination Committee cannot reach an agreement as to the proper division of financial responsibility within ten (10) business days of the initial referral to the Claim Coordination Committee, said claim shall be referred to the Chief Executive Officers (CEO) or the CEO's designee, of both DBM and MCO for resolution immediately. A meeting shall be held among the Chief Executive Officers or their designee(s), of the parties within ten (10) calendar days after the meeting of the Claims Coordination Committee, unless the parties agree to meet sooner.

If the meeting between the CEOs, or their designee(s), of the DBM and MCO does not successfully resolve the dispute within 10 days, the parties shall, within fourteen (14) days after the meeting among the CEOs or their designee(s), submit a request for resolution of the dispute to the state or the state's designee for a decision on responsibility after the service has been delivered.

The process as described above shall be completed within 30 days of receiving the claim for payment. In the event the parties cannot agree within 30 days of receiving the claim for payment, both parties will be responsible for enforcing hold harmless protection for the member and the party who first received the request or claim from the provider will be responsible for authorization and payment to the provider within the following time frames designated by the Bureau of TennCare: claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee. Moreover, the party that first received the request or claim from the provider must also make written request of all requisite documentation for payment and must provide written reasons for any denial.

The Request for Resolution shall contain a concise description of the facts regarding the dispute, the applicable contract provisions, and position of the party making the request. A copy of the Request for Resolution shall also be delivered to the other party. The other party shall then submit a Response to the Request for Resolution within fifteen (15) calendar days of the date of

the Request for Resolution. The Response shall contain the same information required of the Request for Resolution. Failure to timely file a Response or obtain an extension from the state shall be deemed a waiver of any objections to the Request for Resolution.

The state, or its designee, shall make a decision in writing regarding who is responsible for the payment of services within ten (10) days of the receipt of the required information. The decision may reflect a split payment responsibility that will designate specific proportions to be shared by the MCO and the DBM which shall be determined solely by the State, or its designee based on specific circumstances regarding each individual case. Within five (5) business days of receipt of the Decision, the non-successful party shall reimburse any payments made by the successful party for the services. The non-successful party shall also pay to the state, within thirty (30) calendar days of the Decision, an administrative fee equal to ten percent (10%) of the value of the claims paid, not to exceed one-thousand dollars ($1000) for each request for resolution. The amount of the Contractor's payment responsibility shall be contained in the state's Decision. These payments may be made with reservation of rights regarding any such judicial resolution. If a party fails to pay the state for the Contractor's payment responsibility as described in this section within (30) calendar days of the date of the state's Decision, the state may deduct amounts of the Contractor's payment responsibility from any current or future amount owed the party.

A.8.3.2.3 Denial, Delay, Reduction, Termination or Suspension. The parties agree that any claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to an eligible TennCare member ages 0-20. In the event there is a claim for emergency services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency medical services specified in this Agreement.

A.8.3.2.4. Emergencies: Prior authorization shall not be required for emergency services prior to stabilization. Services provided in accordance with the following requirements that are outside of the scope of this agreement shall be considered an MCO responsibility. Coordination activities between the Contractor and the MCOs are outlined in Section A-8 of this agreement.

A.8.3.2.4 (a) Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

A.8.3.2.4 (b) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

A.8.3.2.4 (c.) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment.

A.8.3.2.4 (d) Post stabilization services are covered and paid for in accordance with provisions set forth in 42 CFR 422.113 (c). The MCO is financially responsible for post-stabilization services obtained within or outside the managed care organization that are pre-approved by a plan provider or other MCO representative.

A.8.3.2.4 (e) The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO organization that are not pre-approved by a plan provider or other MCO organization representative, but administered to maintain the enrollee's stabilized

condition within 1 hour of a request to the MCO organization for pre-approval of further post-stabilization care services.

A.8.3.2.4. (f) The MCO is financially responsible for post-stabilization care services obtained within or outside the MCO organization that are not pre-approved by a plan provider or other MCO organization representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

- The MCO does not respond to a request for pre-approval with 1 hour
- The MCO cannot be contacted; or
- The MCO representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c) is met.

A.8.3.2.4 (g) The MCO must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MCO organization.

A.8.3.2.4. (h) the MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the enrollee care;
- A plan physician assumed responsibility for the enrollee's care through transfer;
- An MCO representative and the treating physician reach an agreement concerning the enrollee's care; or
- The enrollee is discharged.

A.8.3.2.5 Claims Processing Requirements. All claims must be processed in accordance with the requirements of the MCO's and DBM's respective Agreements with the State of Tennessee.

A.8.3.2.6 Appeal of Decision. Appeal of any Decision shall be to a court or commission of competent jurisdiction and shall not constitute a procedure under the Administrative Procedure Act, T.C.A. §4-5-201 et seq. Exhaustion of the above-described process shall be required before filing of any claim or lawsuit on issues covered by this Section.

A.8.3.2.7 Duties and Obligations. The existence of any dispute under this Agreement shall in no way affect the duty of the parties to continue to perform their respective obligations, including their obligations established in their respective contracts with the state pending resolution of the dispute under this Section. In accordance with T.C.A. § 56-32-226(b), a provider may elect to resolve the claims payment dispute through independent review.

A.8.3.2.8 Confidentiality. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the state, to cooperate with the state to develop Confidentiality Guidelines that (1) meet state, federal, and other regulatory requirements; (2) meet the requirements of the professions or facilities providing care and maintaining records; and (3) meet both DBM and MCO standards. These standards will apply to both DBM's and MCO's providers and staff. If either party believes that the standards require updating, or operational changes are needed to enforce the standards, the parties agree to meet and resolve these issues. Such standards shall provide for the exchange of confidential e-mails to ensure the privacy of the members.

The DBM and MCO shall assure all materials and information directly or indirectly identifying any current or former enrollee which is provided to or obtained by or through the MCO's or DBM's performance of this Agreement, whether verbal, written, tape, or otherwise, shall be maintained in accordance with the standards of confidentiality of Title 33, Tennessee Code Annotated, Section E.18 of this Agreement, Title 42, Part 2, Code of Federal Regulations, and the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") as amended, and, unless required by applicable law, shall not be disclosed except in accordance with those Titles or to the TennCare Bureau, and the Centers for Medicare and Medicaid Service of the United States Department of Health and Human Services, or their designees. Nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify any current or former enrollee or potential enrollee.

A.8.3.2.9 Access to Service. The DBM agrees and recognizes that the MCO shall agree through its contractual arrangement with the State, to establish methods of referral which assure immediate access to emergency care and the provision of urgent and routine care in accordance with TennCare guidelines.

A.8.4 Tracking System. The Contractor shall develop and maintain a tracking system with the capability to identify the current screening status, pending preventive services, and screening due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each enrollee.

A.8.5. Provider Listing for MCO PCP's. The Contractor shall prepare updated provider listings to be provided to the MCOs for the purpose of distribution to MCO primary care providers. This listing must be provided to MCOs on a quarterly basis in accordance with a form, format and schedule as determined by TennCare.

A.9 PROVIDER SERVICES

A.9.1 Training.

A.9.1.a The Contractor shall provide continuing training for participating Dental Providers throughout the State. The Contractor shall hold at least two training sessions per year for each Grand Region in the state. At a minimum, training shall address EPSDT and the applicable provisions of the *Grier* Consent Decree (modified). The Contractor shall submit all training material to TennCare for approval at least 60 days prior to the training session. TennCare shall have fifteen (15) days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) days of receipt of TennCare's comments.

A.9.1.b The Contractor shall monitor provider compliance with EPSDT requirements and standard dental practice. The Contractor shall work as necessary with Participating Dental Providers to develop corrective action plans to bring Participating Dental Providers, when necessary, into compliance with standard dental practice.

A.9.1.c The Contractor shall notify all network providers to file claims associated with their services directly with the Contractor, or its subcontractors. The Contractor shall provide written instructions to all network providers for submitting claims for payment. The Contractor shall provide individual assistance with policies and billing instructions to providers as requested.

A.9.1.d Documentation of all formal training activities and individualized corrective action assistance will be provided to TennCare on a quarterly basis.

A.9.2. Provider Manual. The Contractor shall produce and distribute a dental program criteria manual to assist Participating Dental Providers. The manual shall clearly define covered services, limitations, exclusions, and utilization management procedures, including, but not limited to: prior approval requirements and special documentation requirements for treatment of members. The manual shall include a detailed description of billing requirements for Participating Dental Providers and shall contain a copy of Contractor's paper billing form and electronic billing format. The Contractor shall produce and distribute

revisions to the manual to participating providers within fifteen days. The Provider Manual and any revisions thereto must be submitted to TennCare for review and approval prior to distribution.

A.9.3. Practice Guidelines: The Contractor shall adopt practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professional in a particular field;
- Consider the needs of the enrollees;
- Are adopted in consultation with contracting health care professionals;
- Are reviewed and updated periodically as appropriate; and
- Are disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

A.10 NETWORK DEVELOPMENT AND MANAGEMENT

A.10.1. Providers Providing On-going Treatment. If an enrollee is in a prior authorized ongoing course of treatment with a participating provider who becomes unavailable to continue to provide services to such enrollee and the Contractor is aware of such ongoing course of treatment, the Contractor shall immediately provide written notice within fifteen (15) calendar days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall include all components identified in the notice template to be provided by TennCare. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the Contractor or when a provider fails credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances.

A.10.2. Other Provider Termination: If a provider ceases participation in the DBM, the Contractor shall make a good faith effort to give a written notice of termination of a contracted provider within 15 days after receipt or issuance of termination notice to each enrollee who received his/her primary care from or was seen on a regular basis by the terminated provider.

A.10.3. Network Deficiency. Upon final notification from TennCare of a network deficiency, which shall be based on the requirements of this Agreement and terms and conditions of the TennCare waiver, the Contractor shall immediately provide written notice to enrollees living in the affected area of a provider shortage in the Contractor's network. The notice content shall be reviewed and approved by TennCare prior to distribution.

A.10.4 Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Said notices shall include, at a minimum; a Contractor's intent to change to a new subcontractors for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed to access services. In addition to prior written notice, the Contractor shall also provide TennCare with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc.

A.10.5. Other Provider Terminations. The Contractor shall notify TennCare of any provider termination and submit a template copy of the enrollee notice sent as well as an electronic listing identifying each enrollee to whom a notice was sent. The Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from TennCare. If the termination was initiated by the provider, said notice shall include a copy of the provider's notification to the Contractor.

A.11 PROVIDER AGREEMENTS

The Contractor shall assure the provision of all covered services specified in this Contract. The Contractor shall enter into agreements with providers and/or provider subcontracting entities or organizations who will provide services to the enrollees in exchange for payment from the State for services rendered. It is the intention of this Contract that the Contractor make every effort to enter into provider agreements with those entities whose practices exhibit a substantive balance between Medicaid and commercial patients.

A.11.1 Provider agreements will be between the provider and Contractor, not between the provider and TennCare.

A.11.2. The Contractor shall submit one copy of all template provider agreements and copies of the face and signature pages of all executed agreements to TennCare.

A.11.3 The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who do not meet all the parameters of the credentialing process as outlined in A.18.5 and Attachment IV, Standard IX.

A.11.4 Further, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance.

A.11.5 All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this Section shall, at a minimum, meet the following requirements: (No other terms or conditions agreed to by the Contractor and provider shall negate or supersede the following requirements.)

A.11.5. a. Be in writing. All new provider agreements and existing provider agreements as they are renewed, must include a signature page that contains Contractor and provider names, which are typed or legibly written, provider company with titles, and dated signatures of all appropriate parties.

A.11.5. b. Specify the effective dates of the provider agreement;

A.11.5. c. Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties;

A.11.5. d. Assure that the provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without approval of the Contractor;

A.11.5. e. Identify the population covered by the provider agreement;

A.11.5. f. Specify that provider may not refuse to provide medically necessary or covered services to a TennCare patient under this Contract for non-medical reasons, including, but not limited to, failure to pay applicable cost sharing responsibilities. The Contractor shall specify that an enrollee who is subject to a copayment requirement, pay applicable TennCare cost share responsibilities prior to receiving non-emergency services. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;

A.11.5. g. Specify the functions and/or services to be provided by the provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice;

A.11.5. h. Specify the amount, duration and scope of services to be provided by the provider;

A.11.5. i. Provide that emergency services for eligible enrollees aged 0-20 be rendered without the requirement of prior authorization of any kind. Retrospective review/authorization will be required.

A.11.5. j. If the provider performs laboratory services, the provider must meet all applicable requirements of the Clinical Laboratory Improvement Act (CLIA) of 1988 at such time that CMS (formerly HCFA) mandates the enforcement of the provisions of CLIA;

A.11.5. k. Require that an adequate record system be maintained for recording services, servicing providers, charges, dates and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the provider agreement). Enrollees and their representatives shall be given access to the enrollees' dental records, to the extent and in the manner provided by T.C.A. Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare provider ends and the enrollee requests that dental records be sent to a second TennCare provider who will be the enrollee's primary dentist, the first provider shall not charge the enrollee or the second provider for providing the dental records;

A.11.5. l. Require that any and all records be maintained for a period not less than five (5) years from the close of the agreement and retained further if the records are under review or audit until the review or audit is complete. Said records shall be made available and furnished immediately upon request for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of authorized representative of the Contractor or TennCare and authorized federal, state and Comptroller personnel;

A.11.5.m. Provide that TennCare and the U.S. Department of Health and Human Services shall have the right to evaluate through inspection, whether announced or unannounced, or other means any records pertinent to this Contract including quality, appropriateness and timeliness of services and such evaluation, and when performed, shall be performed with the cooperation of the provider. Upon request, the provider shall assist in such reviews including the provision of complete copies of medical records;

A.11.5.n. Provide for monitoring, whether announced or unannounced, of services rendered to enrollees sponsored by the Contractor;

A.11.5.o. Whether announced or unannounced, provide for the participation and cooperation in any internal and external QM/QI, utilization review, peer review and appeal procedures established by the Contractor and/or TennCare;

A.11.5. p. Specify that the Contractor shall monitor the quality of services delivered under the agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care which is recognized as acceptable professional practice in the respective community in which the provider practices and/or the standards established by TennCare;

A.11.5. q. Require that the provider comply with corrective action plans initiated by the Contractor or be subject to recoupment of funds, termination or other penalties determined by TennCare;

A.11.5. r. Provide for submission of all reports and clinical information required by the Contractor;

A.11.5.s. Require safeguarding of information about enrollees according to applicable state and federal laws and regulations and as described in Section E-18 of this Agreement;

A.11.5. t. Provide the name and address of the official payee to whom payment shall be made;

A.11.5. u. Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;

A.11.5. v. Provide for prompt submission of information needed to make payment;

A.11.5. w. Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in T.C.A. 56-32-226 and Section A.13.3 of this Agreement;

A.11.5.x. Specify the provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the enrollee's third party payor) plus the amount of any applicable cost sharing responsibilities, as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served;

A.11.5.y. Specify that at all times during the term of the agreement, the provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TennCare and the Contractor. This indemnification may be accomplished by incorporating Section 4-20 of the TennCare/MCO Agreement available at http://www.tennessee.gov/TennCare/providers/TCBHOMCO.html in its entirety in the provider agreement or by use of other language developed by the Contractor and approved by TennCare.

A.11.5.z. Require the provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Plan's enrollees and the Contractor under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish the Contractor with written verification of the existence of such coverage;

A.11.5.aa. Specify both the Contractor and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan;

A.11.5.bb. Provide that any changes in applicable federal and state laws, TennCare rules and regulations or court orders, and revisions of such laws or regulations shall be followed as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and provider agree to negotiate further any amendment as may be necessary to correct any inequities;

A.11.5.cc. Specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the agreement termination date, or early termination of the agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the agreement, then the terms must include provisions allowing at least thirty (30) days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc);

A.11.5.dd. Specify that both parties recognize that in the event of termination of this Agreement between the Contractor and TennCare for any of the reasons described in Section E. 5 of this Agreement, the provider shall immediately make available, to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the Contractor/provider agreement. The provision of such records shall be at no expense to TennCare;

A.11.5.ee. Include provisions for resolution of disputes either by arbitration or another process mutually agreed to by the parties. Specify the TennCare Provider Independent Review of Disputed Claims process shall be available to providers to resolve non-emergency claims denied in whole or in part by the Contractor as provided at T.C.A. 56-32-226(b).

A.11.5.ff. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the agreement between the provider and Contractor to TennCare enrollees and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the Contractor.

Specify that the Contractor shall give providers prior written notice of a determination that a reduction in the provider fee schedule is necessary to remain within the maximum liability of this

Contract and further, specify that the Contractor shall give providers thirty (30) days prior written notice of said reductions and the provider shall agree to the adjusted rates;

A.11.5.gg. Specify that the provider must adhere to Quality of Care Monitors established by TennCare and Contractor and reviewed by the EQRO on an annual basis. The Quality of Care Monitors shall be attached to the provider agreement or specify in the agreement that it will be provided separately.

A.11.5.hh. Specify that a provider shall have at least, but no more than one hundred and twenty (120) calendar days from the date of rendering a health care service to file an initial claim with the Contractor except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the plan with a retroactive eligibility date. In situations of enrollment in the plan with a retroactive eligibility date, the minimum and maximum time frames for filing a claim shall begin on the date that the Contractor receives notification from TennCare of the enrollee's eligibility;

A.11.5.ii. Specify that the provider will comply with the appeal process including but not limited to assisting an enrollee by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review;

A.11.5.jj. Require that the provider display notices of the enrollee's right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare rules, subsequent amendments, or any and all Court Orders;

A.11.5.kk. Require that if any requirement in the provider agreement is determined by TennCare to conflict with the Contract between TennCare and the Contractor, such requirement shall be null and void and all other provisions shall remain in full force and effect;

A.11.5.ll. All provider agreements must include language which informs providers of the package of benefits that EPSDT offers and the periodicity schedule with which those benefits must be provided. All provider agreements must contain language that references the EPSDT benefit package and periodicity schedule, including the information as described in Section A.16 of this Contract, or includes language that states those requirements.

A.11.5.mm. All provider agreements must include a provision which states that providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical or behavioral services covered by TennCare ; and

A.11.5.nn. Specify that in the event that TennCare deems the Contractor unable to timely process and reimburse claims and requires the Contractor to submit provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the provider shall agree to accept reimbursement at the Contractor's contracted reimbursement rate or the rate established by TennCare, whichever is greater.

A.11.5. oo The Contractor shall give TennCare and the Tennessee Department of Commerce and Insurance, TennCare Division, immediate notification in writing by Certified Mail of any administrative or legal action or complaint filed regarding any claim made against the Contractor by a provider or enrollee which is related to the Contractor's responsibilities under this Contract, including but not limited to notice of any arbitration proceedings instituted between a provider and the Contractor. The Contractor shall ensure that all tasks related to the provider agreement are performed in accordance with the terms of this Contract.

A.11.5. pp Specify that the provider warrants that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractors, or consultant to the provider in connection with any work contemplated or performed relative to the agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

A.11.5.qq. Specify that the provider agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this agreement or in the employment practices of the provider on the grounds of disability, age, race, color, religion, sex, national origin, economic status, payment source, or any other classification protected by Federal, Tennessee State constitutional, or statutory law.

A.11.5.rr. Contracts must comply with requirements set forth in the BBA 1997 in 422.208 and 422.210 as it applies to physician incentive plans.

A.11.5.ss. The Contractor shall have in place written policies and procedures for the selection and/or retention of providers and policies and procedures must not discriminate against particular provider that service high risk populations or specialize in conditions that require costly treatment.

A.11.5.tt. The Contractor shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The Contractor's ability to credential providers as well as maintain a separate network and not include any willing provider is not considered discrimination.

A.11.5.uu. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

A.11.5.vv. The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.

i. for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
ii. for any information the enrollee needs in order to decide among all relevant treatment options;
iii. for the risks, benefits, and consequences of treatment or non-treatment; and
iv. for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

A.11.6. Section A.11 shall not be construed to:

A.11.6.a. Require the Contractor to contract with providers beyond the number necessary to meet the needs of the enrollees.

A.11.6.b. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollees

A.12 SUBCONTRACTORS

A.12.1. Legal Responsibility. The Contractor shall be responsible for the administration and management of all aspects of this Agreement and the health plan covered thereunder. If the Contractor elects to utilize a subcontractor, the Contractor shall assure that the subcontractors shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractors for purposes of this Agreement, without approval of the Contractor. No subcontract, provider agreement or other delegation of responsibility terminates or reduces the legal responsibility of the Contractor to TennCare to assure that all activities under this Agreement are carried out. Subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the Contractor provided the services directly (i.e. no balance billing by providers). Contractor must ensure that it evaluates each prospective subcontractor's ability to perform the activities to be delegated and must specify in a written agreement with the subcontractors the activities and report responsibilities delegated to the subcontractors. Contractor

must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The Contractor's written agreement with the subcontractors must address the methodology for identifying deficiencies and providing corrective action plans.

A.12.2 Prior approval. All subcontracts and revisions thereto shall be approved in advance by TennCare. All subcontracts shall be maintained in accordance with the applicable terms of this Agreement. Once a subcontract has been executed by all of the participating parties, a copy of the signature page of the pre-approved contract fully executed subcontract shall be sent to the State within 30 days of execution.

A.12.3. Quality of Care Monitors. If the subcontract is for the purpose of securing the provision of enrollee benefits, the subcontract must specify that the subcontractors must adhere to the Quality of Care Monitors included in the Agreement as Attachment IV. The Quality of Care Monitors shall be included as part of the subcontract between the Contractor and the subcontractors or provided separately at the time the subcontract is executed, provided however, if the Quality of Care Monitors is not included in the subcontract, it shall be referenced in the agreement as being provided separately upon execution of the subcontract.

A.12.4. Limited English Proficiency (LEP) Provisions. The Contractor shall provide instruction for all direct service sub-Contractors regarding the Contractor's written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency.

A.12.5. Assignability. Claims processing subcontracts must include language that requires that the subcontract agreement shall be assignable from the Contractor to the State, or its designee: i) at the State's discretion upon written notice to the Contractor and the affected subcontractors; or ii) upon Contractor's request and written approval by the State. Further, the subcontract agreement must include language by which the subcontractors agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the Contractor.

A.12.6. Claims Processing. All claims for services furnished to a TennCare enrollee filed with the Contractor must be processed by either the Contractor or by one (1) subcontractors retained by the organization for the purpose of processing claims.

A.12.7. HIPAA Requirements. The Contractor shall require all its subcontractors adhere to the HIPAA regulation requirements.

A.12.8. Notice of Subcontractor Termination. When a subcontract that relates to the provision of services to enrollees or claims processing services is being terminated between the Contractor and a subcontractors, the Contractor shall give at least thirty (30) days prior written notice of the termination to TennCare and the TennCare Division, TDCI. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide TennCare with a transition plan, when requested, which shall include, at a minimum, information regarding how prior authorization requests will be handled during and after the transition, how continuity of care will be maintained for the enrollees, etc. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Attachment I and Section E.4. of this Agreement. TennCare reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

A.12.9. Notice of Approval. Approval of subcontracts shall not be considered granted unless TennCare issues its approval in writing.

A.12.10. Subcontract Relationship and Delegation: If the Contractor delegates responsibilities to a subcontractors, the Contractor shall assure that the subcontracting relationship and subcontracting document(s) comply with the requirements of the Balanced Budget Act of 1997, including but not limited to, compliance with the applicable provisions of 42CFR 438.230(b) and 42 CFR 434.6 as described below:

A.12.10.a. The Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

A.12.10.b. The Contractor shall require that the agreement be in writing and specifies the activities and report responsibilities delegated to the subcontractors, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

A.12.10.c. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review consistent with industry standards or State MCO laws and regulations.

A.12.10.d. The Contractor shall identify deficiencies or areas for improvement and the Contractor and the subcontractors shall take corrective action as necessary.

A.13 CLAIMS PROCESSING REQUIREMENTS

The Contractor shall have in place, an automated claims processing system capable of accepting and processing paper claims and claims submitted electronically. The Contractor shall process, as described herein, the provider's claims for covered benefits provided to enrollees consistent with applicable TennCare policies and procedures and the terms of this Agreement. Contractor shall also participate in TennCare efforts to improve and standardize billing and payment procedures.

A.13.1. Electronic Billing System. Contractor shall maintain an electronic data processing system for Claims payment and processing and shall implement an electronic billing system for interested Participating Dental Providers. All Participating Dental Providers should be strongly encouraged and provided the training necessary to submit their claims electronically. The Contractor or any entities acting on behalf of the Contractor shall not charge providers for filing claims electronically. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The Contractor shall comply at all times with standardized paper billing forms/format as follows:

Claim Type	Claim Form
Dental	*ADA*

The Contractor shall not revise or modify the standardized form or format itself. Further, the Contractor agrees to adopt national EMC standards and standardized instructions and definitions that are consistent with industry norms for the forms identified above when developed by TennCare in conjunction with appropriate workgroups.

A.13.2. HIPAA. The Contractor agrees to comply with the Health Insurance Portability and Accountability Act (HIPAA). Further, the Contractor agrees that at such time that TennCare, in conjunction with appropriate work groups presents recommendations concerning claims billing and processing that are consistent with industry norms, the Contractor shall comply with said recommendations within one hundred and eighty (180) days from notice by TennCare to do so.

A.13.3 Timeliness and Accuracy of Payment. The Contractor agrees to comply with prompt pay claims processing requirements in accordance with TCA 56-32-226. Contractor shall ensure that ninety percent (90%) of claims for payment of services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) days of receipt of such claims. The Contractor shall process, and if appropriate pay, within sixty (60) days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the

Contractor shall provide an electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claims.

The Contractor shall contract with independent reviewers for the purposes of said reviewers to review disputed claims as provided by T.C.A. 56-32-226.

Failure to comply with the aforementioned claims processing requirements shall result in the Contractor being required to implement a corrective action plan and shall result in the application of liquidated damages and/or immediate sanctions as described in Section E.4 and Attachment I of this Agreement.

A.13.4 Except where required by the Contractor's Agreement with TennCare or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any dental care provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12.01 a.m. on the effective date of eligibility in the Contractor plan.

A.13.5 When eligibility has been established by TennCare and the enrollee has incurred dental expenses that are covered benefits within the plan, the Contractor shall make reimbursement for the dental services at the regular negotiated rate if the service was provided by a contract provider. If the service was provided by a non-contracted provider, whom the Contractor has agreed to pay only for a specific service, the Contractor shall assure that the enrollee is held harmless by the provider for the costs of the service or procedure. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor or appropriate denial made by the Contractor.

A.14 MANAGEMENT INFORMATION SYSTEMS REQUIREMENTS

A.14.1 Data mapping. The Contractor shall complete all data mapping necessary to submit information to TennCare and respond to information provided by TennCare. This will consist of a cross-reference map of required TCMIS data and Contractor system data elements and data structures. TennCare will make any necessary data formats available to the Contractor.

A.14.2. Daily enrollment updates. The Contractor must have a procedure to maintain and update enrollee profiles that is capable of processing daily updates.

A.14.3. Contractor MIS Interface Requirements. Successful operation of the program requires ongoing interfaces with TCMIS and the Contractor MIS. The TennCare interface standard for data transfers will be via FTP with 36 track compressed cartridges for backup contingency, initial file loads and TennCare selected communications.

In order to ensure the security and confidentiality of all transmitted files, the Contractor must have a system that establishes a dedicated communication line connecting TCMIS to the Contractor's processing site. The cost of this communication line is to be borne solely by the Contractor. This dedicated communication line must meet the following specifications of the TennCare Bureau, OIR and the State of Tennessee:

i. All circuits, circuit terminations and supported network options are to be coordinated through Mr. Ken Barker, Director of Information Services, TennCare, 729 Church Street, Nashville, Tennessee 37247-6501.

ii. Contact TennCare's Director of Information Services before placing all line orders.

iii. Contractor is responsible for providing compatible mode table definitions and NCP configurations for all non-standard system gens.

iv. Contractor is responsible for supplying both host and remote modems for all non-State initiated circuits.

v. Dial-up access into production regions is prohibited.

A.14.4 Readiness Review. Immediately upon identification of Contractor, TennCare will work with Contractor to ensure that their processing system satisfies the functional and informational requirements of Tennessee's TennCare dental program. The Contractor will assist TennCare in the analysis and testing of the information systems and claims processing requirements prior to the delivery or services. The Contractor must provide system access to allow TennCare to test the Contractor's system through the TennCare network. Any software or additional communications network required for access will be provided by the Contractor.

A.14.5 Provider Assistance. The Contractor must be available Monday thru Friday, 7:00 am – 5:00 pm Central Standard Time (CST)/ Central Daylight Savings Time to respond to provider inquiries related to prior approval and claims status.

A.14.6. Help Desk for Prior Approval Operations. The Contractor will maintain toll-free telephone access to support the prior approval process. This Help Desk must be available between the hours of 7:00 a.m. and 5:00 pm, Central Standard Time/ Central Daylight Savings Time, Monday through Friday to respond to questions about Prior Approval Requests.

A.14.7. Data Validation Edits and Audits. The Contractor's claims processing system must perform the following validation edits and audits:

i. Prior Approval - The system must determine whether a covered service requires prior approval, and if so, whether approval was granted by the Contractor.

ii. Valid Dates of Service - The system must assure that dates of services are valid dates, are no older than one hundred eighty (180) days from the date of the service and are not in the future.

iii. Duplicate Claims - The system must automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate.

iv. Covered Service - The system must verify that a service is a valid covered service and is eligible for payment under the TennCare dental benefit for that eligibility group.

v. Provider Validation - The system must approve for payment only those claims received from providers eligible to provide dental services.

vi. Recipient Validation - The system must approve for payment only those claims for recipients eligible to receive dental services at the time the service was rendered.

vii. Eligibility Validation – The system must confirm the enrollee for whom a service was provided was eligible on the date the service was incurred.

viii. Quantity of Service - The system must validate claims to assure that the quantity of services is consistent with TennCare rules and policy.

ix. Rejected Claims - The system must determine whether a claim is acceptable for adjudication and reject claims that are not.

x. Managed Care Organizations - The system must reject claims that should rightly be processed and paid by an enrollee's MCO for any and all physical health treatments.

A.14.8. Prior Approval Request Tracking. Each prior approval request processed by the Contractor will be assigned a unique number and be maintained in a database designed by the Contractor that will contain all pertinent information about the request and be available to Help Desk staff. This information will

include, but not be limited to: provider, recipient, begin and end dates, covered service, request disposition (i.e., approved or denied).

A.14.9. System Security. The Contractor will apply recognized industry standards governing security of State and Federal Automated Data Processing systems and information processing. At a minimum, the State requires the Contractor to conduct a security risk analysis and to communicate the results in a Information Security Plan provided prior to the delivery of services. The risk analysis will also be made available to appropriate Federal agencies.

The following specific security measures should be included in the system design documentation and operating procedures:

i. Computer hardware controls that ensure acceptance of data from authorized networks only.
ii. At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes.
iii. Manual procedures that provide secure access to the system with minimal risk.
iv. Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel.
v. All Contractor MIS software changes are subject to TennCare approval prior to implementation.
vi. System operation functions must be segregated from systems development duties.

A.14.10 Disaster Preparedness and Recovery at the Automated Claims Processing Site. The Contractor must submit evidence that they have a Business Continuity/Disaster Recovery plan for their Central Processing Site. If requested, test results of the plan must be made available to TennCare. The plan must be able to meet the requirements of any applicable state and federal regulations, the TennCare Bureau and Tennessee's OIR.

The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that they meet the following requirements:

i. Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue processing in the event that the central site is rendered inoperable.

ii. Employees at the site must be familiar with the emergency procedures.

iii. Smoking must be prohibited at the site.

iv. Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel.

v. Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested.

vi. The site must be protected by an automatic fire suppression system.

vii. The site must be backed up by an uninterruptible power source system.

A.14.11 Transition Upon Termination Requirements. At the expiration of this Contract, or if at any time the state should terminate this Contract, the Contractor will cooperate with any subsequent Contractor who might assume administration of the dental benefits program. TennCare will withhold final payment to the Contractor until transition to the new Contractor is complete. The state will give the Contractor thirty (30) days notice that a transfer will occur.

In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer, the Contractor will continue to perform MIS operations on a month to month basis for up to six months beyond the planned transfer date.

A.15 COVERED BENEFITS

A.15.1 Covered Benefits: The Contractor shall provide or arrange for the provision of Covered Benefits to members in accordance with the terms of this Agreement, including but not limited to, Section A.1.2 of this Agreement.

A.15.2 Medical Necessity. The determination of medical necessity shall be made on a case by case basis. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The Contractor shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. Any procedures used to determine medical necessity shall be consistent with the following definition.

> Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:
>
> i. Consistent with the symptoms or diagnosis and treatment of the enrollee's condition, disease, ailment or injury; and
> ii. Appropriate with regard to standards of good dental practice; and
> iii. Not solely for the convenience of an enrollee, dentist, institution or other provider; and
> iv. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and
> v. When applied to enrollees under 21 years of age who are eligible for EPSDT, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
> vi. is no more restrictive than the State Medicaid program and
> vii. addresses the extent to which the Contractor is responsible for covering services related to the following:
>
> - The prevention, diagnosis and treatment of health impairments.
> - The ability to achieve age-appropriate growth and development
> - The ability to attain, maintain, or regain functional capacity

A.15.3. EPSDT. The Contractor shall provide Early, Periodic Screening, Diagnostic and follow-up Treatment services as medically necessary to children under the age of twenty-one, who are eligible for EPSDT, in accordance with federal regulations as described in 42 CFR part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21, whether or not such services are covered under the TennCare Program state plan and without regard to any service limits otherwise established in this Contract. This requirement shall be met by either direct provision of the service by the Contractor or by referral, when appropriate, in accordance with 42 CFR 441.61.

A.15.4 Standards of Care. Standards of care shall be taken from published recommendations of nationally recognized authorities such as; The American Dental Association, The American Academy of Pediatric Dentistry and the American Association of Oral and Maxillofacial Surgeons. The standard of care for the community will also be recognized. Participating Dental Providers shall not differentiate or discriminate in the treatment of any member on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status or payment source.

A.15.5 Transportation. Transportation to covered services is a covered service for TennCare members and is the responsibility of the member's MCO. Should transportation to a dental service be necessary for a member, Contractor will coordinate with the MCO to ensure that the transportation is provided.

A.15.6 Coordination with Public Health. Contractor will work closely and cooperatively with the Health Department(s) to accomplish the goals of their School Based Screening Referral, Follow-up, Sealant and TennCare Oral Evaluation and Outreach Program for Children targeting approximately 230,000 children. Identification of children with urgent dental needs as well as identification of children with unmet needs will require Contractor to arrange care for these children according to the access standards identified in Section A.4. of this Agreement. Close coordination between the Oral Health Services Section of the Tennessee Department of Health and the Contractor will be necessary to facilitate referral arrangements and to ensure that encounter data files from the SBDPP are incorporated into encounter data files provided to TennCare.

A.16 EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

A.16.1. EPSDT Dental Services. Contractor shall require Dental Providers to follow practice guidelines for preventive health services identified by TennCare including early periodic screening, diagnosis and treatment services (EPSDT). EPSDT includes timely provision of exams, cleaning, fluoride treatment, sealants and referral for treatment of Child Members. Performance objectives have been established for providing EPSDT services. Contractor will be evaluated on those performance objectives using the annual CMS 416 report which measures the following: any dental service provided using ADA CDT5 codes D0100-D9999; preventive dental services provided using ADA CDT5 codes D1000-D1999 and dental treatment services provided using ADA CDT5 codes D2000-D9999.

A.16.2. Contractor's Outreach Activities. The Contractor shall conduct regularly scheduled outreach activities designed to educate enrollee's about the availability of EPSDT services and to increase the number of children receiving services. Within 45 days of execution of this Agreement, the Contractor shall submit a proposed outreach plan. The Contractor's plan shall identify the target population, service areas, specific outreach activities, schedule for completion and include copies of any material to be released to enrollees. The outreach plan shall be updated at least annually. The proposed plan and any related material shall require approval by TennCare. TennCare shall have thirty (30) days to review material and provide notice of approval or notice to make changes. TennCare may require the Contractor to coordinate its efforts with outreach projects being conducted by TennCare or other state agencies. The Contractor shall submit an annual report to TennCare identifying results of its outreach activities.

Failure to comply with the requirements of this Section may result in the application of intermediate sanctions or liquidated damages as provided in Section E.4. and Attachment I of this Agreement.

A.17 APPEAL SYSTEM REQUIREMENTS

All enrollees shall have the right to file appeals regarding adverse actions taken by the Contractor. For purposes of this requirement, appeal shall mean an enrollee's right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness, or availability of such benefits. The Contractor must notify the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider must be in writing. The Contractor shall provide written materials, reviewed and approved by TennCare, informing enrollees of their appeal rights. The Contractor must notify enrollees in writing of any decision to deny a service authorization request, or to authorize an amount, duration, or scope less than requested. The Contractor shall have appeal procedures in accordance with TennCare rule 1200-13-12-.11 or any applicable TennCare rules, subsequent amendments, or subsequent Court Orders governing the appeals process

A.17.1. Appeals. The Contractor's appeal process shall include, at a minimum, the following:

A.17.1.a The Contractor shall have a contact person appointed. Said person will be knowledgeable of appeal procedures and direct all appeals whether the appeal is verbal or the enrollee chooses to file in writing. Should an enrollee choose to appeal in writing, the enrollee will be instructed to file via mail to the designated P. O. Box for appeals related to the Contractor;

A.17.1.b There shall be sufficient support staff (clerical and professional) available to process appeals in accordance with TennCare requirements related to the appeal of Adverse Actions Affecting a TennCare Program Enrollee. Staff shall be knowledgeable about applicable state and federal law and all court orders governing appeal procedures, as they become effective. This shall include, but not be limited to, appointed staff members and phone numbers identified to TennCare where appropriate staff may be reached;

A.17.1.c Staff shall be educated concerning the importance of the procedure and the rights of the enrollee and the timeframes in which action must be taken by the Contractor regarding the handling and disposition of an appeal;

A.17.1.d. The appropriate individual or body within the Contractor organization having decision-making authority as part of the appeal procedure shall be identified;

A.17.1.e. The Contractor shall have the ability to take telephone appeals and accommodate persons with disabilities during the appeals process. Furthermore, appeal forms shall be available at each service site and by contacting the Contractor. However, enrollees shall not be required to use an appeal form in order to file an appeal;

A.17.1.f. Upon request, the enrollee shall be provided a TennCare approved appeal form(s);

A.17.1.g. All appellants shall have the right to reasonable assistance by the Contractor during the appeal process and must be informed of the rules that govern representation;

A.17.1.h. TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to enrollees, which shall be followed by the Contractor, if TennCare determines that it is in the best interest of the TennCare Program or if necessary to comply with federal or judicial requirements. However, Contractor shall not be precluded from challenging any judicial requirements and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, Contractor shall not be required to comply with such guidelines or rules during any period of such inapplicability.

A.18 QUALITY OF CARE

A.18.1 Quality and Appropriateness of Care. Contractor shall prepare for TennCare approval a written description of a quality monitoring/quality improvement (QM/QI) program, a utilization review program and peer review program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of dental services. The written program shall include an outcomes measurement tool for reporting and measuring results. The plan(s) shall describe who is responsible and the role of the Dental Director in utilization review.

A.18.2 QM/QI Meeting Requirements. The Contractor shall provide the TennCare Dental Director with ten (10) days advance notice of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee and Peer Review Committee. To the extent allowed by law, the Dental Director of TennCare, or his/her designee, may attend the QM/QI meetings at his/her option. In addition, written minutes shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting shall be forwarded to TennCare as required in Section A.19.6. of this Agreement.

A.18.3 Peer Review Committee. The Contractor shall establish a Provider Peer Review Committee which shall meet regularly (no less than quarterly) to review the processes, outcomes and appropriateness of dental care provided to enrollees. The Contractor will submit the names of proposed members to TennCare within sixty (60) days after the execution date of this Agreement. The Contractor's Dental Director shall be the committee chairperson. The Committee shall include at least five (5) Participating Dental Providers who file at least twenty-five (25) TennCare claims per year. This requirement will be waived for the first six (6) months of the contract period if the Contractor can prove an equivalent mechanism for provider peer review during that period.

a. The Committee shall review and recommend appropriate remedial action for any Participating Dental Provider who has provided inappropriate care.
b. The Committee shall coordinate with TennCare's Office of Quality Assurance regarding imposition of any sanctions against a Participating Dental Provider who has provided inappropriate care, including termination. The Office of Quality Assurance should notify the Tennessee Board of Dentistry when indicated.
c. The Committee shall coordinate with TennCare in regard to issues involving fraud or abuse by any Participating Dental Provider as specified in Section E.32.
d. The Committee shall coordinate with the Dental Benefits Manager and TennCare regarding any issues involving recoupment.
e. The Committee shall review and recommend appropriate action on appeals or inquiries provided by Members, Participating Dental Providers, TennCare or other persons regarding quality of care, access or other issues related to TennCare's Dental Program.

A.18.4 Advisory Committee. The Contractor shall participate in an Advisory Committee empowered to review and make recommendations to the Contractor and TennCare concerning the dental program. The Committee shall meet on a schedule established by TennCare. The Committee shall consist of not more than twenty (20) members, two (2) of whom shall be appointed by the Contractor. The Contractor will submit the names of proposed members to TennCare within sixty (60) days after the execution of the Agreement. TennCare shall appoint all other committee members. Members may be selected from dentists serving TennCare members and other parties interested in improving oral health care in Tennessee. TennCare shall also appoint the committee chairperson. The Committee shall review and make recommendations regarding other policies of Contractor regarding services provided under this Agreement.

A.18.5. Credentialing. Contractor is responsible for ensuring that dentists and other oral health professionals, who are under contract to the organization, are qualified to perform their duties. Contractor is responsible for provider selection policies and procedures that cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Contractor is responsible for primary credentialing of providers in accordance with specifications outlined in Attachment IV, Standard IX. If there are changes made to the TennCare credentialing process that are outside the scope of existing contracts, the Contractor will be notified and those additional requirements would have to be satisfied at the Contractor's next scheduled re-credentialing of the provider or when a new provider is added.

A.18.6 Performance Reviews. Contractor shall cooperate with any performance review conducted by TennCare, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the Agreement. Upon reasonable notice, TennCare may conduct a performance review and audit of Contractor to determine compliance with the Agreement. At any time, if TennCare identifies a deficiency in performance, the Contractor will be required to develop a Corrective Action Plan to correct the deficiency including an explanation of how TennCare members will continue to be served until the deficiency is corrected.

A.19. REPORTING REQUIREMENTS

A19.1 Data Base. In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by TennCare, Contractor shall maintain a current data base, in a format acceptable to TennCare, capable of retrieving data on short notice. At a minimum, the database shall include the following data:

Member Name;
Member Identification Number (SSN);
Member MCO;
Dates of Service;
Specific service provided by procedure ADA Code;
Servicing Provider Number (Medicaid #);
Participating Dental Provider Name;

Payment status;
Billed Charge Amount;
Allowed Amount;
Payment Amount;
Received Date;
Payment Date; and
Any other data element required by common dental practice, ADA Guidelines, federal or state law.

Data stored in the database shall be current through the prior week.

A.19.1 Report Requirements. Contractor shall provide to TennCare a Monthly Claim Activity Report, a Monthly Batch Claim Operations Report, a Monthly Encounter Data Report, a Monthly Claims Lag Triangle and a Monthly Provider Data Report with the data elements and in the format and medium (including electronic) requested by TennCare. Record layout and other information about report submission is available at the TennCare Information Systems Library. Contractor shall also provide such additional reports, or make revisions in the data elements or format of the reports upon request of TennCare without additional charge to TennCare. TennCare shall provide written notice of such requested revisions of format changes in a Notice of Required Report Revisions. Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of this Agreement. TennCare may impose liquidated damages or monetary sanctions under Section E.4 and Attachment I of the Agreement based upon Contractor's failure to timely submit Standard Reports in the required format and medium. In addition, Contractor shall provide the following reports:

A.19.2 Referral Time. Contractor shall submit a monthly report on the number of requests for assistance to obtain an appointment as specified in Section A.6.4. The first report under this Agreement, covering the month of January 2006, shall be due on February 28, 2006. Thereafter, reports shall be due thirty (30) days after the end of each calendar month. The report shall provide sufficient information to allow TennCare to determine the number of requests by county and the time required to locate a Participating Dental Provider willing to serve the Member who is seeking an appointment for Covered Services.

A.19.3 Audited Financial Statements and Income Statements. Contractor shall provide to TennCare copies of its annual audited financial statements no later than ninety (90) days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) days after the end of each calendar quarter.

A.19.4 EPSDT Outreach Reports. Contractor shall provide an annual EPSDT Outreach Report that describes the outreach activities completed in the preceding year, results of those activities, lessons learned, and how future activities will be modified to incorporate lessons learned.

A.19.5 Response Time Reports. Contractor shall provide TennCare with a monthly report of response times on Contractor's Member Services and Provider Services telephone lines. The target answer time for these lines is 30 seconds and the benchmark will be 60 seconds. The first report will be due for the month of January 2006 and will be due by February 28, 2006. Thereafter, reports will be due thirty (30) days after the end of the calendar month.

A.19.6. Meeting Reports. Contractor shall submit the minutes of its Utilization Review Committee meetings, Quality Assurance Committee meetings and the Peer Review Committee meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact shall be reported.

A.19.7 Non-discrimination Compliance Information. The Contractor shall demonstrate compliance with Federal and State regulations of Title VI of the Civil Rights Act of 1964 as outlined in Attachment III.

A.19.8 Satisfaction Surveys. Contractor shall conduct, at a minimum, an annual Member Satisfaction Survey and an annual Provider Satisfaction Survey. The Contractor shall obtain approval from TennCare prior to conducting Member and Provider Satisfaction Surveys. Further, the Contractor shall submit a report to TennCare identifying key findings.

A.19.9 Public Filings. Contractor shall promptly furnish TennCare with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this Agreement.

A.19.10 Enrollee Cost Share Reporting: The Contractor shall report enrollee cost-sharing liabilities on a quarterly basis in the manner and form described by TennCare.

A.20 ENROLLMENT AND DISENROLLMENT

A.20.1. Enrollment. TennCare is responsible for the enrollment of enrollees in the Contractor's plan.

a. The Contractor shall accept daily eligibility data from the State (DCS or TennCare Select for Immediate eligibility for children in state custody).

b. The Contractor shall accept the enrollee in the health condition the enrollee is in at the time of enrollment.

c. Enrollment shall begin at 12:01 a.m. on the effective date that the enrollee is enrolled in the Contractor's plan and shall end at 12:00 midnight on the date that the enrollee is disenrolled pursuant to the criteria in TennCare policy and/or TennCare rules and regulations. Women who are determined presumptively eligible are given immediate TennCare eligibility and a temporary identification form to confirm eligibility pending the issuance of a regular identification card by their selected MCO. The purpose of this temporary identification/eligibility confirmation form is to enable the women to access prenatal care at the earliest possible time. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during presumptive period of enrollment. In order to give children entering into DCS custody adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility, the Contractor shall accept notice from DCS and/or TennCare Select of TennCare "immediate" eligibility. If the child is not currently enrolled, the Contractor shall immediately build a forty-five (45) day eligibility record effective on the date the child was placed in state custody and identify the child as a child in state custody. The Contractor shall be responsible for arranging for the provision of services and payment of all covered services during immediate eligibility period of enrollment.

In regards to EPSDT reporting, the Contractor will continue to only report on those children whose TennCare eligibility status is permanent, who are assigned to the DBM.

A.20.2. Disenrollment. TennCare is responsible for the disenrollment of enrollees from the Contractor's plan. The Contractor shall not disenroll enrollees. The Contractor, may, however, provide TennCare with any information it deems appropriate for TennCare'S use in making a decision regarding loss of eligibility or disenrollment of a particular Member.

a. No enrollee shall be disenrolled from a health plan for any of the following reasons:
Adverse changes in the enrollee's health; Pre-existing medical conditions;
High cost medical bills, a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees); or Failure or refusal to pay applicable cost-sharing fees, except when TennCare has approved such disenrollment.

b. The Contractor's responsibility for disenrollment shall be to inform TennCare promptly when the Contractor knows or has reason to believe that an enrollee may satisfy any of the conditions for disenrollment described in TennCare policy and/or TennCare rules and regulations.

Actions taken by TennCare cannot be grieved by the Contractor.

A.21 THIRD PARTY LIABILITY

A.21.1. The Contractor may not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or payment will not be available within a reasonable time.

A.21.2. All funds recovered from third parties will be treated as offsets to claims payments.

A.21.3 The Contractor shall provide any information necessary to assist and shall cooperate in any manner necessary as requested by TennCare, with a Cost Recovery Vendor at such time that TennCare acquires said services.

A.21.4 If the Contractor has determined that third party liability exists for part or all of the services administered directly by the Contractor the Contractor shall make reasonable efforts to recover from third party liable sources the value of services rendered. This may be accomplished through the Contractor's provider network and does not require the Contractor to directly recover from third party sources.

A.21.5 If the Contractor has determined that third party liability exists for part or all of the services provided to an enrollee by a provider, the Contractor shall pay the provider only the amount, if any, by which the provider's allowable claim exceeds the amount of third party liability.

A.21.6 Cost sharing responsibilities permitted pursuant to Section A.1.3 of this Agreement shall not be considered third party resources for purposes of this requirement.

A.21.7 The Contractor shall provide third party resource (TPR) data to any provider having a claim denied by the Contractor based upon a TPR.

A.21.8 Third party resources shall include subrogation recoveries. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system received during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

A.22 PROVIDER PAYMENT

A.22.1 Provider Payment Process

a. Dental Service Payments. The Contractor is not at financial risk for the provision of covered benefits to enrollees. The Contractor shall prepare checks for payment on at least a weekly basis, unless an alternative payment schedule is approved by TennCare. The Contractor shall notify the State of the amount to be paid in a mutually acceptable form and substance at least 48 hours in advance of distribution of provider checks. The State shall release funds in the amount to be paid to the providers to the Contractor. Funds shall be released within 48 hours of receipt of notice. In turn, the Contractor shall release payments to providers within 24 hours or receipt of funds from the State.

b. Interest. Interest generated from the deposit of funds for provider payments shall be the property of the State. The amount of interest earned on the funds, as reported by the Contractor's bank on the monthly statement, shall be deducted from the amount of the next remittance request subsequent to receipt of the bank statement.

c. Subrogation Recoveries. The amount of provider payments specified in Section A.22.1.a shall be net of third party recoveries captured on the Contractor's claims processing system prior to notification of TennCare of the amount to be paid. The amount of any subrogation recoveries collected by the Contractor outside of the claims processing system shall be the property of the State. On a monthly basis, the Contractor shall report to the State the amount of any subrogation recoveries collected outside the claims processing system during the previous month. The next remittance request subsequent to this monthly report shall be reduced by the value of the subrogation recoveries reported.

d. IRS Form 1099. Contractor shall prepare and mail Internal Revenue Service ("IRS") Form 1099 on behalf of Providers who receive payments under this Agreement. Contractor shall provide a hard copy and, if requested, a magnetic tape transfer of Form 1099 information to TennCare for

subsequent delivery to the entity responsible for reporting such Form 1099 information to the IRS.

e. Service Dates. Except where required by the Contractor's Agreement with TennCare or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any medical care provided prior to the effective date of eligibility in the Contractor's plan. The Contractor shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of eligibility in the Contractor's plan.

f. Covered Services. The State shall only assume responsibility for payment of providers for the provision of covered services as specified in Section A.1.2 of this Agreement and payment of providers or enrollees in response to a directive from TennCare or an Administrative Law Judge. Otherwise, in the event the Contractor makes payment for a non-covered service, the State shall not be responsible for the payment of said service.

g. Cost-Sharing. Payments for covered services specified in Section A.1.2 shall not include payment for enrollee cost-sharing amounts.

A.22.2 Allowable Rates .TennCare has established the fee schedule for this contract which is attached at Attachment VI. Claims will be paid at the lesser of billed charges or the TennCare fee schedule. Contractor shall not deviate from the approved reimbursement rates, unless TennCare provides written permission to do so.

A.23 FINANCIAL REQUIREMENTS

If during the life of this Agreement, TennCare directs the Contractor to operate as a risk-bearing entity for dental services, the Contractor shall establish and maintain all financial reserves required by the Tennessee Department of Commerce and Insurance of HMOs, Third Party Administrator or Prepaid Limited Health Services Organizations licensed by the State of Tennessee, including, but not limited to, the reserves required by Tennessee Code Annotated, Section 56-32-212 as amended or Section 56-51-136 as amended. The Contractor shall demonstrate evidence of its compliance with this provision to the Tennessee Department of Commerce and Insurance, TennCare Division, in the financial reports filed with that Department by the Contractor. The Contractor must notify the State of any person or corporation that has 5% or more ownership or controlling interest in the entity and such person or corporation must submit financial statements. The Contractor, unless a Federally Qualified HMO, must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the entity becomes insolvent.

A.24. PERFORMANCE OBJECTIVES

A.24.1 Administration and Management

The following performance indicators related to administration and management have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan or application of intermediate sanctions or liquidated damages as specified in Section E.4 and Attachment I of this Agreement.

Performance Indicator	Data Sources	Measure	Target	Benchmark
Claims Payment Accuracy	Monthly Claims Activity Report	# of claims paid accurately upon initial submission	100 percent	97% accuracy upon initial submission

Performance Indicator	Data Sources	Measure	Target	Benchmark
Approximate Waiting Time for Provider Response	Monthly Response Time Report	Average response time on provider services line	Average response time of 30 seconds	Average response time of 60 seconds
Abandonment rate for Member Services lines	Monthly Response Time Report	Percent of calls not answered; callers hang up while in queue	0 percent	Less than 5 percent of calls not answered
Approximate Waiting Time for Member Response	Monthly Response Time Report	Average Response Time on Member Services Line	Average response time of 30 seconds	Average response time of 60 seconds

A.24.2 The following performance indicators related to EPSDT have been identified for on-going monitoring. The Contractor's failure to meet these benchmarks shall result in the Contractor being required to implement a corrective action plan as described in Section A.18.6.

Performance Indicator	Data Sources	Measure	Target	Benchmark
EPSDT	Encounter data; TennCare enrollment data	Dental Screening Percentage (DSP) for TennCare children receiving any dental service age 3 & older divided by TennCare children age 3 and older utilizing CMS 416 Health Screen Methodology.	80% screening	10 Percentage point increase in DSP over previous year, or outreach efforts reasonably calculated to ensure participation of all children who have not received screenings.

A.24.3 Performance Guarantees. The Contractor agrees TennCare may assess penalties for failure to meet the Performance Guarantees specified below in addition to the intermediate sanctions and liquidated damages specified in Section E.4 and Attachment I. Penalties for failure to meet a performance guarantee shall not be passed on to a provider and/or subcontractors unless the penalty was caused due to an action or inaction of the provider and/or subcontractors. All penalties shall be considered an administrative cost to the Contractor.

Performance Area	Data Sources	Definition	Guarantee	Penalty
Network	**1.** Monthly	**1.** Time and travel	**1.** Provider network	**1.** $25,000 if

Performanc e Area	Data Sources	Definition	Guarantee	Penalty
Adequacy	Provider listing	distance as measured by GeoAccess	includes sufficient numbers and geographical disbursement of providers in order to satisfy the Terms and Conditions for Access of the TennCare Waiver	ANY of the listed standards are not met, either individually or in combination on a monthly basis. The penalty may be lowered to $5,000 in the event that the Contractor provides a corrective action plan that is accepted by TennCare
	2. Most recent monthly provider listing and random phone surveys conducted by TennCare on a quarterly basis	**2.** Network validation	**2.** At least 90% of records for participating providers on the most recent monthly provider listing can be used to contact the provider and confirm the provider is participating in the DBM's network	**2.** $25,000 if less than 90% of records can be used to contact the provider and confirm participation on a quarterly basis. The penalty may be lowered to $5,000 in the event that the Contractor provides a corrective action plan that is accepted by TennCare, or waived if the Contractor submits sufficient documentation to demonstrate 90% of providers are participating

A. 25. OBLIGATIONS OF THE STATE

A.25.1 Program Rules and Procedures. TennCare shall provide Contractor, as necessary for the Performance of the Contractor obligations, the rules, policies and procedures regarding the benefits and claims payments applicable to coverage under the Dental Program.

A.25.2 Enrollment and Disenrollment. TennCare shall also be responsible for enrollment of eligible persons in the Contractor's plan and for disenrollment of ineligible persons from the Contractor's plan. TennCare will arrange for the Contractor to have updated eligibility information in the form of on-line computer access

and will notify the Contractor when TennCare determines that there is any change in an enrollee's demographic information.

A.25.3 Verification of Eligibility. TennCare provides a means for dental providers to verify Member eligibility on line. The Contractor may provide additional means of eligibility verification to its contracted dentists.

A.25.4 Payment to Contractor. TennCare shall pay Contractor pursuant to Section C.1 of this Agreement for Contractor's performance of all duties and obligations hereunder. No additional payment shall be made to Contractor by TennCare for the services required under this Agreement, the RFP, and the Contractor's Proposal, including all attachments.

B. CONTRACT TERM

B.1. Contract Term. This contract shall be effective for the period commencing on October 1, 2005 and ending on September 30, 2008 subject to TennCare Readiness Review approval and approval by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services and provided there is continuous approval of the TennCare 1115 waiver by the Centers for Medicare and Medicaid Services during this time period. TennCare shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2. Term Extension. TennCare reserves the right to extend this Contract, in increments of one (1) year each, for an additional two (2) years, provided that TennCare notified Contractor in writing of its intention to do so at least ninety (90) days prior to the Contract expiration date. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in TennCare's maximum liability will also be effected through an amendment to the Contract and shall be based upon rates negotiated with the Contractor for the extension period. Extension of the Contract is also contingent upon continuous approval of the TennCare 1115 waiver by the Centers for Medicare and Medicaid Services during these time periods. Renegotiations may be made for good cause, only at the end of the contract period and for modification(s) during the contract period, if circumstances warrant, at the discretion of the State.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed [WRITTEN DOLLAR AMOUNT] ($[NUMBER AMOUNT]). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

The maximum liability of the State for compensation and services provided to enrollees under the provider agreements shall be defined annually. At such time that the State's incurred expenditures are projected under this contract to reach fifty percent (50%) of the annual maximum liability for compensation and services provided to enrollees, the Contractor shall notify the State and the Contractor and the State agree to re-evaluate the terms of this Contract to determine if an amendment to this contract is required to effect adjustments that must be made (provider fee schedule adjustments, etc) in order to assure the maximum liability for the State for compensation and services provided to enrollees is not exceeded.

C.2. Compensation Firm. The Service Rates and the Maximum Liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3. Payment Methodology. The Contractor shall be compensated based on the Service Rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor shall be compensated based upon the following Service Rates at the conclusion of the readiness review at which time the Contractor transition period will conclude and actual assumption of services from previous Contractor will begin. Beginning January 1, 2006, the Contractor shall be compensated based on a fixed fee per member per month as specified below. Each month payment to the Contractor shall be equal to the number of enrollees certified by TennCare multiplied by the administrative fee for the appropriate enrollee category. The Contractor's payment shall be based on enrollment at the lst day of each month of the contract period. Monthly compensation will not be adjusted upward or downward during the month based on fluctuating eligibility unless the fluctuation is due to a mass transfer of enrollees, in which case the Contractor will be compensated for those individuals on the date of transfer. Payment shall be made by the fifth working day of each month.

EFFECTIVE DATES	* ADMINISTRATIVE FEE PER CHILD (Under Age 21) ELIGIBLE FOR THE FULL DENTAL BENEFIT PACKAGE
October 1, 2005 – September 30, 2008 **	

* PMPM: Per Member Per Month

**Although Contract Effective date is October 1, 2005, actual delivery of services begins January 1, 2006 after conclusion of three month readiness review

RENEWAL OPTION RATES	
October 1, 2008 - September 30, 2010	

*PMPM: Per Member Per Month

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.6. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

C.7. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.8. Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

C.9 The Contractor shall allow for periodic review of records to ensure that all discounts, special pricing considerations and financial incentives have accrued to the State and that all costs incurred are in accordance with this Agreement. The Contractor shall provide the auditor access to all information necessary to perform the examination.

Further, TennCare, the Centers for Medicare and Medicaid Services (CMS), or their agents shall at least annually monitor the operation of the Contractor for compliance with the provisions of this Agreement and applicable federal and state laws and regulations. Such monitoring activities shall include, but are not limited to, inspection of Contractor's facilities, auditing and/or review of all records developed under this Agreement including periodic medical audits, appeals, enrollments, disenrollments, termination, utilization and financial records, reviewing management systems and procedures developed under this Agreement and review of any other areas or materials relevant to or pertaining to this Agreement. Because of the importance of having accurate service utilization data for program management, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. TennCare shall prepare a report of its findings and recommendations and require the Contractor to develop corrective action plans as appropriate.

C.10 The Contractor shall maintain all records and files regarding the submission of Claims and corresponding payments for five (5) years and provide data that may be required for regulatory, audit insurance and other business purposes.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2. Modification and Amendment. This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations. This Agreement shall be amended automatically without action by the parties whenever required by changes in state and federal law or regulations. In the event of a Partial Default, the Agreement shall be amended automatically to conform with written notices from TennCare of the Contractor regarding the effect of the Partial Default upon this Agreement. No other modification or change of any provision of the Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and TennCare and incorporated as a written amendment to this Agreement prior to the effective date of such modification or change.

D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the State. The State shall give the Contractor at least sixty (60) days written notice before the effective termination date. The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, they shall contain, at a minimum, sections of this Contract pertaining to "Conflicts of Interest" and "Nondiscrimination" (sections D.6. and D.7.). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime Contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractors, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8. Records. The Contractor shall maintain documentation for all charges against the State under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.9. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.10. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.11. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.12. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint ventures, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor, being an independent Contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.

D.13. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.14. Force Majeure. The obligations of the parties to this contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, acts of God, riots, wars, strikes, epidemics or any other similar cause.

D.15. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.16. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.17. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.18. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.19. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:

Deputy Commissioner
Tennessee Department of Finance and Administration
310 Great Circle Road
Nashville, Tennessee 37243
(615) 741-0213
(615) 741-0882

The Contractor:

_____
_____
_____

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the fax machine at the receiving location and receipt is verbally confirmed by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by United States mail on the same date of the facsimile transmission.

E.3. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4. Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

I) failure to perform in accordance with any term or provision of the Contract;
II) partial performance of any term or provision of the Contract;
III) any act prohibited or restricted by the Contract, or
IV) violation of any warranty.

For purposes of this contract, items I through IV shall hereinafter be referred to as a "Breach."

E.4.a. Contractor Breach— In event of a Breach by Contractor, the state shall have available the following remedies as described further herein. Before imposing any sanction against the Contractor other than termination of the contract, the State shall provide the Contractor entity with notice and such other due process protections as the State may provide, except that a State may not provide the Contractor with a predetermination hearing before the appointment of temporary management.

E.4.a.i. Actual Damages and any other remedy available at law or equity;

E.4.a.ii. Liquidated Damages— the State may withhold as liquidated damages the amounts designated on Attachment I of this contract from any amounts owed Contractor.

E.4.a.ii.(1) The State shall notify Contractor in writing of the Breach and the amounts to be withheld as Liquidated Damages.

E.4.a.ii.(2) The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the liquidated damages contained in Attachment I and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach.

E.4.a.ii.(3) It is hereby agreed between the parties that the liquidated damages represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include: any injury or damage sustained by a third party and Contractor agrees that the liquidated damage amount is in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract;

E.4.a.ii.(4) The State may continue to withhold the liquidated damages or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the Contract.

E.4.a.ii.(5) The State is not obligated to assess liquidated damages before availing itself of any other remedy.

E.4.a.ii.(6) The State may choose to discontinue liquidated damages and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said liquidated damages previously withheld except in the event of a Partial Default.

E.4.a.iii. Partial Default

E.4.a.iii.(1) In the event the State declares a Partial Default, the State shall provide written notice to the Contractor of the following:

E.4.a.iii.(1)(a) The date which Contractor shall terminate providing the service associated with the Breach; and

E.4.a.iii.(6) Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4.a.iii.(7) Contractor agrees to cooperate fully with the State in the event a Partial Default is taken.

E.4.a.iv. Termination of the Contract — In the event of a Breach by Contractor, the State may terminate the Contract immediately or in stages.

E.4.a.iv.(1) The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice.

E.4.a.iv.(2) The Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages.

E.4.a.iv.(3) The Contractor agrees to cooperate with the State in the event of a termination, Partial Default or Partial Takeover and must supply all information necessary for reimbursement of outstanding Medicaid claims.

E.4.a.iv.(4) In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity.

E.4.a.iv.(5) In the event of a termination, the Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract.

E.4.b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within thirty (30) days of any Breach of contract by the State. Said notice shall contain a description of the Breach.

E.4.b.i. Failure by the Contractor to provide the written notice described in section E.4.b. shall operate as an absolute waiver by the Contractor of the State's Breach.

E.4.b.ii. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract.

E.4.b.iii. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described in section E.4.b. operates as a waiver of the State's Breach.

E.4.b.iv. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the notice described in section E.4.b. shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.5. Partial Takeover. The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including but not limited to

any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.6. Termination Plan. The Contractor must have a termination plan to be implemented in the event the contract between TennCare and the Contractor is terminated for any of the above stated reasons. Records must be retained in accordance with the requirements of 45 CFR 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends.

E.7. Annual Report and Audit. The Contractor shall prepare and submit, within nine (9) months after the close of the reporting period, an annual report of its activities funded under this Contract to the commissioner or head of the contracting agency, the Tennessee Comptroller of the Treasury, and the Commissioner of Finance and Administration. The annual report for any Contractor that receives $500,000 or more in aggregate federal and state funding for all its programs shall include audited financial statements. All books of account and financial records shall be subject to annual audit by the Tennessee Comptroller of the Treasury or the Comptroller's duly appointed representative. When an audit is required, the Contractor may, with the prior approval of the Comptroller, engage a licensed independent public accountant to perform the audit. The audit contract between the Contractor and the licensed independent public accountant shall be on a contract form prescribed by the Tennessee Comptroller of the Treasury. Any such audit shall be performed in accordance with generally accepted government auditing standards, the provisions of OMB Circular A-133, if applicable, and the *Audit Manual for Governmental Units and Recipients of Grant Funds* published by the Tennessee Comptroller of the Treasury. The Contractor shall be responsible for reimbursement of the cost of the audit prepared by the Tennessee Comptroller of the Treasury, and payment of fees for the audit prepared by the licensed independent public accountant. Payment of the audit fees of the licensed independent public accountant by the Contractor shall be subject to the provisions relating to such fees contained in the prescribed contract form noted above. Copies of such audits shall be provided to the designated cognizant state agency, the State Contracting Department, the Tennessee Comptroller of the Treasury, and the Department of Finance and Administration and shall be made available to the public.

E.8. Independent Review of the Contractor. In accordance with Chapter 4 of the waiver approved by the Centers for Medicare and Medicaid Services may select a PRO, Private Accreditation Organization or an External Quality Review Organization (EQRO) to provide a periodic or an annual independent review of the Contractor. The results of the review shall be provided to TennCare and to the Contractor and shall be available, on request, to the Department of Health and Human Services, the Office of Inspector General and General Accounting Office.

E.9. State Ownership of Work Products. The State shall have all ownership right, title, and interest, including ownership of copyright, in all work products created, designed, developed, derived, documented, installed, or delivered to the State under this Contract. The State shall have royalty-free and unlimited rights to use, disclose, reproduce, or publish, for any purpose whatsoever, all said work products. The Contractor shall furnish such information and data upon request of the State, in accordance with the Contract and applicable State law.

E.10. Performance Bond. Upon approval of the Contract by all appropriate State officials in accordance with applicable State laws and regulations, the Contractor shall furnish a performance bond in the amount equal to Two Million Dollars ($2,000,000.00), guaranteeing full and faithful performance of all undertakings and obligations under this Contract for the initial Contract term and all extensions thereof. The bond shall be in the manner and form prescribed by the State and must be issued through a company licensed to issue such a bond in the State of Tennessee.

The Contractor shall obtain the required performance bond in form and substance acceptable to the State and provide it to the State no later than September 16, 2005. Failure to provide the performance bond prior to the deadline as required shall result in contract termination.

In lieu of a performance bond, a surety deposit in the sum of two million dollars ($2,000,000.00) may be substituted if approved by the State prior to its submittal.

E.11. Printing Authorization. The Contractor agrees that no publication coming within the jurisdiction of *Tennessee Code Annotated*, Section 12-7-101, *et. seq*., shall be printed unless a printing authorization number has been obtained and affixed as required by *Tennessee Code Annotated*, Section 12-7-103 (d).

E.12. Incorporation of Additional Documents. Included in this Contract by reference are the following documents:

a. The Contract document and its attachments
b. All Clarifications and addenda made to the Contractor's Proposal
c. The Request for Proposal and its associated amendments
d. Technical Specifications provided to the Contractor
e. The Contractor's Proposal

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these documents shall govern in order of precedence detailed above.

E.13. Work-Papers Subject to Review. The Contractor shall make all audit, accounting, or financial analysis work-papers, notes, and other documentation available for review by the Comptroller of the Treasury or his representatives, upon request, during normal working hours either while the analysis is in progress or subsequent to the completion of this Contract.

E.14. Lobbying.

A. Definitions

(1) Lobbying means to communicate, directly or indirectly, with any official in the legislative or executive branch, for pay or for any consideration, for the purpose of influencing any legislative action or administrative action. (T.C.A. § 3-6-102(13))

(2) Public Official means any elected official, appointed official, or employee of:

(a) A federal, State or local unit of government in the U.S.

(a) A government corporation. (2 U.S.C.A. § 1602(15)(A) and (B))

(3) Official in the Executive Branch means the governor, any member or the governor's staff, any member or employee of a state regulatory commission, including, without limitation, directors of the Tennessee regulatory authority, or any member or employee of any executive department or agency or other state body in the executive branch. (T.C.A. § 3-6-102(16))

(4) Official in the Legislative Branch means any member, member-elect, any staff person or employee of the General Assembly or any member of a commission established by and responsible to the General Assembly or either house thereof who takes legislative action. This includes the Secretary or State, Treasurer, and Comptroller of the Treasury and any employee of such offices. (T.C.A. § 3-6-102(17))

B. The Contractor further certifies by signing this Agreement, to the best of its knowledge and belief, that Federal funds have not been used for lobbying in accordance with 45 CFR 93.100 and 31 U.S.C.A. 1352. Regardless of funding source, lobbyist compensation cannot be directly or indirectly contingent on 1) the passage or defeat of a bill related to TennCare or sister health

departments, 2) the number of covered TennCare enrollees, 3) or the amount of TennCare reimbursement to a vendor. Certification from the Contractor must include the following:

(1) No appropriated funds may be expended by the recipient of this Agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress, an elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS or any other federal agency in connection with this Agreement or subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor.

(2) The Contractor must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment VII) with TennCare and the TennCare Oversight Committee that the Contractor is in compliance with all state and federal laws relating to conflicts of interest and lobbying. This form must be signed by the Chief Executive Officer of the Contractor or his/her designee and must be received by TennCare and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor. The certification must also include signed copies of any contracts or agreements as well as a list of individual entities who have been lobbied or influenced.

Failure by the Contractor to comply with the provisions herein shall result in termination of the Contract and/or liquidated damages as provided in Section D.4 and Attachment I.

E.15. Offer of Gratuities

By signing this Agreement, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office, Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This Agreement may be terminated by TennnCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the Agreement and/or liquidated damages as provided in Section D.4 and Attachment I of this Agreement.

E.16. Public Funding Notice. All notices, informational pamphlets, press releases, research reports, signs, and similar public notices prepared and released by the Contractor relative to this Contract shall include the statement, “This project is funded under an agreement with the State of Tennessee.” Any such notices by the Contractor shall be approved by the State.

E.17. Prohibited Advertising. The Contractor shall not refer to this Contract or the Contractor's relationship with the State hereunder in commercial advertising in such a manner as to state or imply that the Contractor or the Contractor's services are endorsed.

E.18. Confidentiality of Records. Strict standards of confidentiality of records shall be maintained in accordance with the law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with State law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State’s information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

E.19. Copyrights and Patents. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims or suits which may be brought against the State for infringement of any laws regarding patents or copyrights which may arise from the Contractor's performance of this Contract. In any such action brought against the State, the Contractor shall satisfy and indemnify the State for the amount of any final judgment for infringement. The Contractor further agrees it shall be liable for the reasonable fees of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State. The State shall give the Contractor written notice of any such claim or suit and full right and opportunity to conduct the Contractor's own defense thereof.

E.20. Public Accountability. If this Contract involves the provision of services to citizens by the Contractor on behalf of the State, the Contractor agrees to establish a system through which recipients of services may present grievances about the operation of the service program, and the Contractor agrees to display a sign stating:

"NOTICE: This Contractor is a recipient of taxpayer funding. if you observe an employee engaging in any activity which you consider to be illegal or improper, please call the State Comptroller's toll free hotline: 1-800-232-5454"

Said sign shall be displayed in a prominent place, located near the passageway(s) through which the public passes to receive State funded services.

E.21. Environmental Tobacco Smoke. Pursuant to the provisions of the federal "Pro-Children Act of 1994" and the Tennessee "Children's Act for Clean Indoor Air of 1995," the Contractor shall prohibit smoking of tobacco products within any indoor premises in which services are provided pursuant to this Contract to individuals under the age of eighteen (18) years. The Contractor shall post "no smoking" signs in appropriate, permanent sites within such premises. This prohibition shall be applicable during all hours, not just the hours in which children are present. Violators of the prohibition may be subject to civil penalties and fines. This prohibition shall apply to and be made part of any subcontract related to this Contract.

E.22. Hold Harmless. The Contractor agrees to indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees from and against any and all claims, liabilities, losses, and causes of action which may arise, accrue, or result to any person, firm, corporation, or other entity which may be injured or damaged as a result of acts, omissions, or negligence on the part of the Contractor, its employees, or any person acting for or on its or their behalf relating to this Contract. The Contractor further agrees it shall be liable for the reasonable cost of attorneys for the State in the event such service is necessitated to enforce the terms of this Contract or otherwise enforce the obligations of the Contractor to the State.

In the event of any such suit or claim, the Contractor shall give the State immediate notice thereof and shall provide all assistance required by the State in the State's defense. The State shall give the Contractor written notice of any such claim or suit, and the Contractor shall have full right and obligation to conduct the Contractor's own defense thereof. Nothing contained herein shall be deemed to accord to the Contractor, through its attorney(s), the right to represent the State of Tennessee in any legal matter, such rights being governed by ***Tennessee Code Annotated***, Section 8-6-106.

E.23. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in ***Tennessee Code Annotated***, Section 8-36-801, *et. seq*., the

law governing the Tennessee Consolidated Retirement System, provides that if a retired member returns to State employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent Contractor, the Contractor may be required to repay to the Tennessee Consolidated Retirement System the amount of retirement benefits the Contractor received from the Retirement System during the period of this Contract.

E.24. Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency;

b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining attempting to obtain, or performing a public (Federal, State, or Local) transaction or grant under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;

c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and

d. have not within a three (3) year period preceding this Contract had one or more public transactions (Federal, State, or Local) terminated for cause or default.

E.25. Date/Time Hold Harmless. As required by ***Tennessee Code Annotated*** Section 12-4-118, the Contractor shall hold harmless and indemnify the State of Tennessee; its officers and employees; and any agency or political subdivision of the State for any breach of contract caused directly or indirectly by the failure to computer software or any device containing a computer processor to accurately or properly recognize, calculate, display, sort or otherwise process dates or times.

E.26. Effect of the Federal Waiver on this Agreement. The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of Tennessee by the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement. Said termination shall not be a breach of this Agreement by TennCare and TennCare shall not be responsible to the Contractor or any other party for any costs, expenses, or damages occasioned by said termination.

E.27 Exigency Extension. At the option of the State, the Contractor agrees to continue services for the Department when TennCare determines that there is a public exigency that requires the contracted services to continue. Continuation of services pursuant to this section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) days notice shall be given by TennCare before this option is exercised. During any periods of public exigency, the Contractor shall be reimbursed at the rate in place immediately prior to the exigency extension.

E.28. Contractor Qualifications. At the inception of this Agreement and at all times during the life of this agreement, the Contractor shall be appropriately licensed to operate within the State of Tennessee. If during the life of this Agreement TennCare directs the Contractor to operate as a risk bearing entity for dental services, Contractor shall be at all times material licensed in the State of Tennessee as an Insurance Company pursuant to TCA Section 56-2-101 *et seq*., a Health Maintenance Organization pursuant to TCA Section 56-32-201 *et seq*., a Prepaid Licensed Health Services Organization, pursuant to TCA 56-51-101, *et seq*., or as a Dental Service Plan pursuant to TCA Section 56-30-101 *et seq*. The Contractor must maintain its license as a Third Party Administrator, not withstanding any other licensure requirements, until such time as TDCI notifies the Contractor otherwise.

E.28.1 Disclosures. The Contractor shall disclose to TennCare full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts of 1999. This disclosure shall be made at time and on forms prescribed by TennCare but no less frequently than on an annual basis to be provided no later than January 1 of each calendar year. TennCare and/or the US Department of Health and Human Services may request information to be in the form of a consolidated financial statement. The following information shall be disclosed:

E.2 8.1.a. The name and address of each person with an ownership or control interest in the disclosing entity or in any provider or subcontractors in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.

E.28.1.b The identity of any provider or subcontractors with whom the Contractor has had business transactions totaling more than one thousand dollars ($1,000) during the twelve (12) month period ending on the date of the disclosure.

E.28.1.c. The identify of any person who has an ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Federal Title XX services program since the inception of those programs.

E.29. Action by the Department of Commerce & Insurance. The parties acknowledge that the Contractor is licensed to operate in the State of Tennessee, and is subject to regulation, examination and supervision by the Tennessee Department of Commerce and Insurance.

E.30. Applicability of this Agreement. All terms, conditions, and policies stated herein apply to staff, agents, officers, subcontractors, providers, volunteers and anyone else acting for or on behalf of the Contractor. TennCare enrollees are the intended third party beneficiaries of contracts between the state and managed care organizations and of any subcontracts or provider agreements entered into by managed care organizations with subcontracting providers and, as such, enrollees are entitled to the remedies accorded to third party beneficiaries under the law. This provision is not intended to provide a cause of action against the Bureau of TennCare or the State of Tennessee by enrollees beyond any that may exist under state or federal law.

E.31. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document.

E.32. Tennessee Bureau of Investigation Medicaid Fraud and Abuse Unit (MFCU)
Access to Contractor and Provider Records Office of TennCare Inspector General Access to Contractor, Provider, and Enrollee Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations, MFCU and TennCare OIG shall be health oversight agencies as defined at 45 C.F.R. §§ 164.501 and 164.512(d) and 65 F.R. § 82462. When acting in their respective capacities as health oversight agencies, MFCU and TennCare OIG do not need authorization to obtain enrollee protected health information (PHI). Because MFCU and TennCare OIG will request the information mentioned above for health oversight activities, "minimum necessary" standards do not apply to disclosures to MFCU or TennCare OIG that are required by law. See 45 C.F.R. §§ 164.502(b)(2)(iv), 164.502(b)(2)(v), and 164.512(d).

The Contractor shall immediately report to MFCU all factually based known or suspected fraud, abuse, waste and/or neglect of a provider or Contractor, including, but not limited to, the false or fraudulent filings of claims and/or the acceptance or failure to return money allowed or paid on claims known to be false or fraudulent. The Contractor shall not investigate or resolve the suspicion, knowledge or action without informing MFCU, and must cooperate fully in any investigation by MFCU or subsequent legal action that may result from such an investigation.

The Contractor and all its health care providers who have access to any administrative, financial, and/or medical records which relate to the delivery of items or services for which TennCare monies are expended, shall, upon request, make them available to MFCU or TennCare OIG. In addition, the MFCU must be allowed access to the place of business and to all TennCare records of any Contractor or health care provider, during normal business hours, except under special circumstances when after hour admission shall be allowed. MFCU shall determine any and all special circumstances.

The Contractor and its participating and non-participating providers shall report TennCare enrollee fraud and abuse to TennCare OIG. The Contractor and/or provider may be asked to help and assist in investigations by providing requested information and access to records. Shall the need arise, TennCare OIG must be allowed access to the place of business and to all TennCare records of any TennCare Contractor or health care provider, whether participating or non-participating, during normal business hours.

The Contractor shall inform its participating and non-participating providers that as a condition of receiving any amount of TennCare payment, the provider must comply with this Section of this Contract regarding fraud, abuse, waste and neglect.

E.32.a. Prevention/Detection of Provider Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

E.32.b. Fraud and Abuse Compliance Plan

E.32.b.(1) The Contractor shall have a written Fraud and Abuse compliance plan. A paper and electronic copy of the plan shall be provided to the TennCare Program Integrity Unit. The Contractor's specific internal controls and polices and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the TennCare Program Integrity Unit within ninety (90) days of the effective date of this Agreement. The TennCare Program Integrity Unit shall provide notice of approval, denial, or modification to the Contractor within thirty (30) days of review. The Contractor shall make any requested updates or modifications available for review to TennCare and/or the TennCare Program Integrity Unit as requested by TennCare and/or the TennCare Program Integrity Unit within thirty (30) days of a request. The State shall not transfer their law enforcement functions to the Contractor. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;

ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract:

iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:

(a) Claims edits;
(b) Post-processing review of claims;
(c) Provider profiling and credentialing;
(d) Prior authorization;
(e) Utilization management;
(f) Relevant subcontractors and provider agreement provisions;
(g) Written provider and enrollee material regarding fraud and abuse referrals.

iv. Contain provisions for the confidential reporting of plan violations to the designated person as described in item 3 below;

v. Contain provisions for the investigation and follow-up of any compliance plan reports;

vi. Ensure that the identities of individuals reporting violations of the plan are protected;

vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;

viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to TBI MFCU and that enrollee fraud and abuse be reported to the TennCare Program Integrity Unit;

ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

E.32.b(2) The Contractor shall comply with the applicable requirements of the Model Compliance Plan for HMOs when the final model plan is issued by the U.S. Department of Health and Human Services, the Office of Inspector General (OIG).

E.32.b(3) The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

E.32.b(4) The Contractor shall submit an annual report to the TennCare Program Integrity Unit that includes summary results of fraud and abuse tests performed as required by 1-5.b.1.iii. and detailed in the Contractor's Fraud and Abuse compliance plan. The report should cover results for the year ending June 30 and be submitted by September 30 each year. This information in this report shall be provided in accordance with and in a format as described in the Contractor's approved compliance plan.

E.33. Solvency. The Contractor must provide assurances that Medicaid enrollees will not be liable for the Contractor's debt if the DBM becomes insolvent. The Contractor must cover the continuation of services to enrollees for the duration of the period for which payment has been made.

E.34. Conflict of Interest

The Contractor warrants that during the term of this Agreement no payments shall be paid to the following:

(1) any State or federal officer, including but not limited to

a. a member of the State Legislature, or
b. a member of Congress, or
c. any immediate family member of any State or federal officer; or

(2) any State or federal employee or any immediate family member of a State or federal employee unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. Immediate family members may be exempted if State or federal officer or employee discloses such relationship to TennCare and the TennCare Oversight Committee. The applicability of this section includes, but is not limited to, any and all arrangements and/or agreements, written or verbal, that result in the Contractor making a payment or providing a gift in exchange for services or supplies.

The Contractor must certify annually by filing a TennCare Disclosure of Lobbying Activities Form (Attachment VII) with TennCare and the TennCare Oversight Committee that the Contractor is in compliance with all state and federal laws relating to conflicts of interest and lobbying, having made diligent inquiry of all subcontractors and/or persons receiving payment or gifts from Contractor pursuant to this Agreement. This form must be signed by the Chief Executive Officer of the Contractor or his/her designee and must be received by TennCare and the TennCare Oversight Committee no later than December 31 of each year beginning with December 31, 2005. The certification must include any and all subcontractors, vendors, agents, providers, representatives and others with verbal or written agreements with the Contractor which receive reimbursement through this Agreement from the Contractor. The Chief Executive Officer acknowledges that he/she is responsible for ensuring that internal controls are in place to prevent and detect potential conflicts of interest and that due diligence was performed before providing certification of compliance. Any changes by the Contractor relating to the disclosure of conflicts of interest or lobbying must be disclosed to TennCare within five (5) business days of the date of the change. (Refer to E.14, lobbying activities).

This Agreement may be terminated by TennCare if it is determined that the Contractor, its agents or employees offered or gave gratuities of any kind to any official, employee or immediate family member of an employee of the State of Tennessee, including a member of the State legislature. This Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees.

Failure to comply with the provisions required herein shall result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of this Agreement as described in Section E.4 and Attachment I, Liquidated damages, and subject to termination of this Agreement.

The Contractor shall be responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and include the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from this Agreement between Contractor and TennCare.

E.35. State and Federal Compliance. The Contractor agrees to comply with all applicable federal and state laws and regulations, and court orders, including Constitutional provisions regarding due process and equal protection of the laws and including but not limited to:

E.35.a. Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (with the exception of those parts waived under the TennCare Section 1115(a) waiver).

E.35.b. Title 45 CFR, Part 74, General Grants Administration Requirements.

E.35.c. All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.).

E.35.d. Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 C.F.R. Part 80.

E.35.e. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e) in regard to employees or applicants for employment.

E.35.f. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 C.F.R. Part 84.

E.35.g. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance.

E.35.h. Omnibus Budget Reconciliation Act of 1981, P.E.. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance.

E.35.i. Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101 et seq., and regulations issued pursuant thereto, 28 C.F.R. Parts 35, 36.

E.35.j. Sections 1128 and 1156 of the Social Security Act relating to exclusion of providers for fraudulent or abusive activities involving the Medicare and/or Medicaid program.

E.35.k. Tennessee Consumer Protection Act, T.C.A. Section 47-18-101 et seq.

E.35.l. The CMS waiver and all Special Terms and Conditions which relate to the waiver.

E.35.m Executive Orders, including Executive Order 1 effective January 26, 1995.

E.35.n. The Clinical Laboratory Improvement Act (CLIA) of 1988.

E.35.o. Requests for approval of material modification as provided at TCA 56-32-201 etc .seq.

E.35.p. Title IX of the Education Amendments of 1972 (regarding education programs and activities)

E.35.q. The Rehabilitation Act of 1973

E.35.r. The Balanced Budget Act of 1997 Section 422.208 and 422.210

E.35.s. EEO Provisions

E.35.t. Copeland Anti-Kickback Act

E.35.u. Davis-Bacon Act

E.35.v. Contract Work Hours and Safety Standards

E.35.w. Rights to Inventions Made Under a Contract or Agreement

E.35.x. Byrd Anti-Lobbying Amendment

E.35.y. Debarment and Suspension

E.36. Offer of Gratuities

By signing this Agreement, the Contractor signifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the General Accounting Office,

Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially from this procurement. This Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, his agent, or employees and may result in termination of the Agreement and/or liquidated damages as provided in Attachment I of this Agreement.

IN WITNESS WHEREOF:

[CONTRACTOR LEGAL ENTITY NAME]:

[NAME AND TITLE]	**Date**

DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE:

M. D. Goetz, Jr., Commissioner	**Date**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr., Commissioner	**Date**

COMPTROLLER OF THE TREASURY:

John G. Morgan, Comptroller of the Treasury	**Date**

ATTACHMENT I

LIQUIDATED DAMAGES

It is acknowledged by TennCare and the Contractor that in the event of failure to meet the requirements provided in this Agreement and all documents incorporated herein, TennCare will be harmed. The actual damages which TennCare will sustain in the event of and by reason of such failure are uncertain, are extremely difficult and impractical to ascertain and determine. The parties therefore acknowledge that the Contractor shall be subject to damages and/or sanctions as described below. It is further agreed that the Contractor shall pay TennCare liquidated damages as directed by TennCare and not to exceed the fixed amount as stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Agreement requirements listed below but for TennCare's failure to perform as provided in this Agreement, the Contractor shall not be liable for damages resulting directly therefrom.

I. TennCare may impose any or all of the sanctions below upon TennCare's reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the Agreement, provided, however, that TennCare only impose those sanctions it determines to be appropriate for the deficiencies identified. TennCare may impose intermediate sanctions on the Contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

Intermediate sanctions may include application of liquidated damages as described in Section E.4.a.ii.

II. Liquidated Damages

Reports and Deliverables

For each day that a report or deliverable is late, incorrect, or deficient, the Contractor shall be liable to TennCare for liquidated damages in the amount of $100 per work day per report or deliverable. Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc or on-request reports involving provider network information), or deficient deliverables shall begin on the sixteenth day after notice is provided from TennCare to the Contractor that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of ad hoc or on-request reports involving provider network information, liquidated damages for incorrect reports shall begin on the first day the report is determined by TennCare to be incorrect. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the following schedule, unless otherwise specified elsewhere in this Agreement:

DELIVERABLES		**DATE AGREED UPON BY THE PARTIES**
Monthly Reports		20th of the following month.
Quarterly Reports, excluding SURS		30th of the following month.
Annual Reports		Ninety (90) calendar days after the end of the contract year. (September 30th)
On Request Reports		Within three (3) working days from the date of request when reasonable unless otherwise specified by TennCare.
Ad Hoc Reports		Within ten (10) working days from the date of the request when reasonable unless otherwise specified by TennCare.

Program Issues

Liquidated damages for failure to perform specific responsibilities as described in this Agreement are shown below. Damages are grouped into three categories: **Class A** violations**, Class B** violations and **Class C** violations.

Class A violations are those which pose a significant threat to patient care or to the continued viability of the TennCare program.

Class B violations are those with pose threats to the integrity of the TennCare program, but which do not necessarily imperil patient care.

Class C violations are those which represent threats to the smooth and efficient operation of the TennCare program but which do not imperil patient care or the integrity of the TennCare program.

CLASS	PROGRAM ISSUES		DAMAGE
A.1	Failure to comply with claims processing as described in A.13 of this Agreement including making timely responses to provider requests for payment and/or claims information		$10,000 per month, for each month that TennCare determines that the Contractor is not in compliance with the requirements of A.13 of this Agreement.
A.2	Failure to respond to a request by DCS or TennCare to provide service(s) to a child in DCS custody or at risk of entering DCS custody		$1000 per occurrence
A.3	Failure to comply with obligations and timeframes in the delivery of EPSDT screens and related services		$1000 per occurrence
A.4	Denial of a request for services to a child in DCS custody or at risk of entering DCS custody when the services have been reviewed and authorized by the TennCare Chief Medical Officer		$1000 per occurrence
A.5	Failure to provide a service or make payments for a service within five (5) calendar days of a reasonable and appropriate directive from TennCare to do so or within a longer period of time which has been approved by TennCare upon a plan's demonstration of good cause.		$500 per day beginning on the next calendar day after default by the plan.
A.6	Services wrongfully withheld where enrollee was not receiving the service and the enrollee went without coverage of the disputed service while an appeal on the service was pending.		$1,000 per occurrence
A.7	Failure to comply with the notice requirements of the TennCare rules and regulations or any subsequent amendments thereto, and all court orders governing appeal procedures,		$500 per calendar day for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set

	as they become effective.		forth by this Agreement or required by TennCare
A.8	Failure to provide continuation or restoration of services where enrollee was receiving the service as required by the TennCare rules or any subsequent amendments thereto, all applicable state or federal law, and all court orders governing appeal procedures as they become effective.		$500 per occurrence.
A.9	Failure to forward an expedited appeal to TennCare in twenty-four (24) hours or a standard appeal in five (5) days.		$500 per calendar day.
A.10	Failure to comply with marketing and communication limitations including, but not limited to use of unapproved and/or disapproved marketing and communication material.		$1000 per occurrence.
B.1	Failure to provide listings of participating dentists to enrollees as required by this Agreement		$500 per calendar day.
B.2	Failure to complete or comply with corrective action plans as required by TennCare		$500 per calendar day for each day the corrective action is not completed or complied with as required.
B.3	Failure to comply with Conflict of Interest requirements as described in Section E.34.		110% of the total amount of compensation paid by the Contractor to inappropriate individuals as well as termination of this agreement.
B.4.	Failure to submit Disclosure of Lobbying Activities Form by Contractor as specified in Section E.34.		$250 per calendar day.
B.5.	Failure to comply with Offer of Gratuities constraints described in Section E.15.		110% of the total benefit provided by the Contractor to inappropriate individuals and possible termination of the Agreement for Breach as described in Section E.4.
C.1	Employment of licensed personnel		$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulations.
C.2	Failure to comply in any way with staffing requirements as described in Section A.3. of this Agreement		$250 per calendar day for each day that staffing requirements as described in Section A.3. of this Agreement are not met.
C.3	Failure to report provider notice of termination of participation in the		$200 per day.

	Contractor's plan		

III. Payment of Liquidated Damages

It is further agreed by TennCare and the Contractor that any liquidated damages assessed by TennCare shall be due and payable to TennCare within thirty (30) calendar days after Contractor receipt of the notice of damages and if payment is not made by the due date, said liquidated damages may be withheld from future payments by TennCare without further notice. It is agreed by TennCare and the Contractor that the collection of liquidated damages by TennCare shall be made without regard to any appeal rights the Contractor may have pursuant to this Agreement; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by TennCare will be immediately returned to the Contractor. With respect to Class B and Class C violations, the due dates mentioned above may be delayed if the Contractor can show good cause as to why a delay should be granted. TennCare has sole discretion in determining whether good cause exists for delaying the due dates.

Liquidated damages as described herein shall not be passed to a provider and/or subcontractors unless the damage was caused due to an action or inaction of the provider and/or subcontractors. Nothing described herein shall prohibit a provider and/or a subcontractors from seeking judgment before an appropriate court in situations where it is unclear that the provider and/or the subcontractors caused the damage by an action or inaction. All liquidated damages imposed pursuant to this Agreement, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits.

ATTACHMENT II

Evidence of Coverage and Enrollee Material

I. Enrollee Materials: The Contractor shall distribute various types of enrollee materials within its entire service area as required by this Agreement. These materials include, but may not be limited to member handbooks, provider directories, member newsletters, fact sheets, notices, or any other material necessary to provide information to enrollees as described herein. The Contractor may distribute additional materials and information, other than those required by this Section, to enrollees in order to promote health and/or educate enrollees. All materials sent to enrollees and enrollee communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by TennCare prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this Agreement. Letters sent to enrollees in response to an individual query do not require prior approval. The required enrollee materials include the following:

I. A. Member Handbooks. The Contractor shall develop and update their member handbook when major changes occur within the TennCare program, the DBM or upon request by TennCare. The member handbooks shall contain the actual date it was printed either on the handbook or on the first page within the first page of the handbook. Member handbooks must be distributed to enrollee within thirty (30) days of receipt of notice of enrollment in the DBM plan. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) member handbook to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent new or updated member handbooks are mailed to enrollee. Should a single individual be enrolled and be added into an existing case, a member handbook new or updated must be mailed to that individual regardless of whether or not a member handbook has been previously mailed to enrollee in the existing case. However, upon notice by TennCare of benefit changes, the Contractor shall make the appropriate revisions to (2) separate versions of the Contractor's TennCare Member Handbook for the specific population being serviced for the purpose of describing Medicaid Benefits to the Medicaid populations and Standard benefits to the Standard population. All revisions must be approved prior to dissemination. The Contractor shall submit an electronic file and ten (10) printed final versions of the final product to the TennCare Marketing Coordinator within thirty (30) working days from the print date. If the print date exceeds thirty (30) working days from the date of approval, the Contractor shall submit a written notification to the TennCare Marketing Coordinator to specify a print date. Photo copies may not be submitted as a final product. When large distributions of the member handbook occur, the Contractor must submit to TennCare the date the information was mailed to the enrollees along with an invoice or a specific document to indicate the date and volume of handbooks mailed. Each member handbook shall, at a minimum, be in accordance with the following guidelines:

I.A.1. Must be in accordance with all applicable requirements as described in this Attachment.

I.A.2. Shall include a table of contents;

I.A.3. Shall include an explanation on how members will be notified of member specific information such as effective date of enrollment.

I.A.4. Shall include a description of services provided including limitations, exclusions and out-of-plan use;

I.A.5. Shall include a description of cost share responsibilities for non Medicaid eligible individuals including an explanation that providers and/or the DBM may utilize whatever legal actions that are available to collect these amounts;

I.A.6. Shall include information about preventive services for children, to include a listing of preventive services and notice that preventive services are at no cost and without cost share responsibilities.

I.A.7. Shall include procedures for obtaining required services, including procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to providers outside of the plan. The handbook

should advise members that if they need a service that is not available within the plan, they will be referred to a provider outside of the plan and any co-payment requirements would be the same as if this provider were in the plan;

I.A.8. Shall include an explanation of emergency services and procedures on how to obtain emergency services both in and out of the Contractor's service area;

I.A.9. Shall include appeal procedures as described in Section A.17. of the pro forma contract;

I.A.10. Shall include notice to the enrollee that in addition to the enrollee's right to file an appeal for actions taken by the Contractor, the enrollee shall have the right to request reassessment of eligibility related decisions directly to the Department of Human Services.

I.A.11. Shall include written policies on member rights and responsibilities.

I.A.12. Shall include written information concerning advance directives as described in the Code of Federal Regulations, 42 CFR 489 Subpart I and in accordance with 42 CFR 417.436.(d);

I.A.13. Shall include the toll free telephone number for TennCare with a statement that the enrollee may contact the plan or TennCare regarding questions about TennCare. The TennCare Family Assistance Service Center number is 1-866-311-4287.

I.A.14. Shall include information on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

I.A.15. Shall include information educating enrollees of their rights and necessary steps to amend their data in accordance with HIPAA regulations.

I.A.16. Shall include other information on requirements for accessing services to which they are entitled under the contract including factors such as physical access and non-English languages spoken as required in the Balanced Budget Act of 1997, Section 438.10(f)3.

I.A.17. Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P/E/ 97-35) and a complaint form on which to do so.

I.B. Quarterly Newsletter**:** The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all enrollees which is intended to educate the enrollee to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The Contractor shall include the following information, in each newsletter:

I.B.1 specific articles or other specific information as described when requested by TennCare. Such requests by TennCare shall be limited to two hundred (200) words and shall be reasonable including sufficient notification of information to be included;

I.B.2 the procedure on how to obtain information in alternative formats or how to access interpretation services as well as a statement that interpretation and translation services are free; and

I.B.3 For TennCare Medicaid enrollees, EPSDT information, including but not limited to, encouragement to obtain screenings and other preventive care services.

Not more than one hundred twenty (120) calendar days shall elapse between dissemination of this information. In order to satisfy the requirement to distribute the quarterly newsletter to all enrollees, it shall be acceptable to mail one (1) quarterly newsletter to each address associated with the enrollee's TennCare case number. In addition to the prior authorization requirement regarding dissemination of materials to enrollees, the Contractor shall also submit to TennCare an electronic file and five (5) final printed originals of the newsletter and the date that the information was mailed to enrollees along with an invoice or other type of documentation to indicate the date and volume of the quarterly newsletter mailing.

I.B.4 Shall include notice to the enrollee of the right to file a complaint as is provided for by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35) and a Contractor contact phone number for doing so. The notice shall be in English and Spanish.

I.C. Provider Directory. The Contractor shall be responsible for distributing provider directories to new members within thirty (30) calendar days of receipt of notification of enrollment in the plan. The Contractor shall also be responsible for redistribution of updated provider information on a regular basis. The provider directories shall include the following: names, locations, telephone numbers, office hours, non-English languages spoken by current network providers, and identification of providers accepting new patients. Enrollee provider directories, and any revisions thereto, shall be submitted to TennCare for approval prior to distribution to enrollees. Each submission shall include a paper and an electronic copy. The text of the directory shall be in Microsoft Word or Adobe (PDF) format. In addition, the provider information used to populate the enrollee provider directory shall be submitted as a TXT file or such format as otherwise approved by TennCare and be produced using the same extract process as the actual enrollee provider directory. In situations where there is more than one enrollee in a TennCare case, it shall be acceptable for the Contractor to mail one (1) provider directory to each address listed for the enrollee's TennCare case number when there is more than one (1) new enrollee assigned to the same case number at the time of enrollment and when subsequent updated provider directories are mailed to enrollees. Should a single individual be enrolled and be added into an existing case, a provider directory must be mailed to that individual regardless of whether or not a provider directory has been previously mailed to enrollees in the existing case.

The Contractor may choose to provide a modified provider listing to enrollees who are only eligible for the limited Dental Benefits as described in Section A.1.2.3 of this Agreement. However, all provider directories shall be approved by TennCare prior to the Contractor's distribution.

II. **Permissible Communication Activities**: The following enrollee communication activities shall be permitted under this contract pending approval of a communication/outreach/access plan describing the time(s), place(s), intent, audience and other relevant information requested by TennCare.

II.A. Distribution of general information through mass media;

II.B. Telephone calls, mailings and home visits to current enrollees of the Contractor only for the sole purpose of educating current enrollees about services offered by or available through the Contractor;

II.C. General activities that benefit the entire community (e.g., health fairs, school activity sponsorships, and health education programs)

III. **Prohibited Communication Activities**: The following information and activities are prohibited:

III.A. Materials and/or activities that mislead, confuse or defraud or that are unfair or deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers;

III.B. Overly aggressive solicitation, such as repeated telephoning;

III.C. Gifts and offers of material gain or financial gain as incentives;

III.D. Compensation arrangements that utilize any type of payment structure in which compensation is tied to the number of persons enrolled;

III.E. Direct solicitation of potential enrollees; and

III.F. In accordance with federal requirements, independent marketing agents shall not be used in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions.

III.G. Seeking to influence enrollment in conjunction with the sale or offering of any private insurance.

IV. Written Material Guidelines

IV.A. All materials shall be worded at a 6th grade reading level, unless TennCare approves otherwise.

IV.B. All written materials shall be clearly legible with a minimum font size of 12pt.with the exception of member I.D. cards, and unless otherwise approved by TennCare.

IV.C. All written materials shall be printed with an assurance of non-discrimination in both English and Spanish.

IV.D. The following shall not be used on communication material without the written approval of TennCare:

IV.D.1 The Seal of the State of Tennessee;

IV.D.2 The TennCare℠ name unless the initials “SM” denoting a service mark, is superscripted to the right of the name;

IV.D.3. The word “free” can only be used if the service is no cost to all members.

IV.E. All documents and the member handbook must be translated and available in Spanish. Within ninety (90) days of notification from TennCare, all vital documents must be translated and available to each Limited English Proficiency group identified by TennCare that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.

IV.F. All written materials shall be made available in alternative formats for persons with special needs or appropriate interpretation services shall be provided by the Contractor.

IV.G. The Contractor shall develop a written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency. The Contractor shall provide for those enrollees, language help-lines with specific numbers. The Contractor shall provide instruction for its staff and all direct service sub-Contractors regarding the procedure.

IV.H. The Contractor shall provide written notice of any changes in policies or procedures described in written materials previously sent to enrollees. The Contractor shall provide written notice at least thirty (30) days before the effective date of the change.

ATTACHMENT III

Non-discrimination Compliance Information

No person, on the grounds of handicap and/or disability, age, race, color, religion, sex, or national origin, shall be excluded from participation in, except as specified in Section A-1 of this Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of this Agreement or in the employment practices of the Contractor. The Contractor shall, upon request, show proof of such non-discrimination and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.

In order to demonstrate compliance with Federal and State regulations of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, the Age Discrimination Act of 1975 and the Omnibus Budget Reconciliation Act of 1981 (P.E. 97-35), the Contractor shall:

1. Designate a staff person to be responsible for Title VI non-discrimination compliance on behalf of the Contractor. The designated staff person shall be identified by name in writing to TennCare within thirty (30) days of the effective date of this Agreement. The Contractor does not have to require that non-discrimination compliance be the sole function of the designated staff person.

    a. In respect to any period of time that the Contractor does not have a designated staff person responsible for Title VI compliance it shall be reported to TennCare in writing, to the attention of the Director of Non-discrimination Compliance within ten (10) calendar days of the commencement of such period of time. At such time that this function is redirected, the name of the staff member who assumed the duties shall be reported to TennCare, to the attention of the Director of Non-discrimination Compliance within ten (10) calendar days of the change.

    b. The Contractor's non-discrimination compliance coordinator shall develop a written procedure for the provision of language interpretation and translation services for enrollees with Limited English Proficiency. The Contractor shall provide instruction for its staff, including but not limited to, the designated staff person for Title VI, and all direct service sub-Contractors regarding the procedure.

    c. On an annual basis, submit a copy of the Contractor's personnel policies that, at a minimum; emphasize non-discrimination in hiring, promotional, operational policies, contracting processes and participation on advisory/planning boards or committees.

    d. On a quarterly basis, a summary listing totaling the number of supervisory personnel by race/national origin and sex. The Contractor is required to request this information from all Contractor staff. Contractor staff response is voluntary. The Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decisions regarding employment or in determination of compensation amounts. Such listing shall separate categories for total supervisory personnel by; number of male supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin as indicated by staff and number of female supervisors who are White, Black (not of Hispanic origin), American Indian or Alaskan Native, Asian or Pacific Islander, Hispanic origin and other race/national origin females as indicated by staff.

    e. On an annual basis, a summary listing by CSA of servicing providers which includes race or ethnic origin of each provider. The listing shall include, at a minimum, provider name, address, race/ethnic origin (to be indicated as in Attachment III, Section 1.d above) and shall be sorted by CSA. Each provider type (e.g. general dentists, oral surgeon, etc.) shall be reported separately within the CSA. The Contractor is required to request this information from all providers. Provider response is voluntary. The

Contractor is prohibited from utilizing information obtained pursuant to such a request as a basis for decision regarding participation in the Contractor's provider network or in determination of compensation amounts.

f. On a quarterly basis, a listing of all complaints alleging discrimination filed by employees (when the complaint is related to TennCare benefits provided by the Contractor) enrollees, providers and subcontractors in which discrimination is alleged in the Contractor's TennCare Plan. Such listing shall include, at a minimum, the identity of the party making the complaint, the complainant's relationship to the Contractor, the circumstances of the complaint, the date the complaint was filed, Contractor's resolution, if resolved, and the name of Contractor staff person responsible for adjudication of the complaint.

g. On a quarterly basis, a listing of all requests for translation/interpretation services by requesting enrollee.

(1) Each request reported will identify by name and member identification number the enrollee for which translation/interpretation service was provided, the date of the request, the date provided, and the identification of the translator/interpreter.

h. On an annual basis, a copy of the Contractor's policy, that demonstrates non-discrimination in provision of services to persons with Limited English Proficiency.

(1) A listing of the interpreter/translator services utilized by the Contractor in providing services to enrollees with Limited English Proficiency. The listing shall provide the full name of interpreter/translator services, address of services, phone number of services, hours services are available and be sorted by CSA.

i. On an annual basis, the Contractor's Title VI Compliance Plan and Assurance of Non-discrimination.

ATTACHMENT IV

GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF ORGANIZATIONS CONTRACTING WITH TennCare

Each Organization which contracts with TennCare (also referred to as the State) shall have in place an internal quality monitoring system. Internal Quality Monitoring programs (QMPs) consist of systematic activities, undertaken by the organization itself to monitor and evaluate the care delivered to enrollees according to predetermined, objective standards, and to effect improvements as needed. The following guidelines will be used to establish State standards for internal QMPs for TennCare Contractors.

The guidelines were derived from three sources:

- The National Committee for Quality Assurance (NCQA) Quality Assurance Managed Care Organization Surveyor Guidelines, 2000;

- The National Association of HMO Regulators/National Association of Insurance Commissioners' Recommended Operational Requirements for HMO Quality Assurance Programs, adopted by the NAIC/NAHMOR Joint Task Force, December, 1988;

- The CMS Office of Prepaid Health Care's Quality Assurance Standards for HMOs and CMPs Contraction with the Medicare Program, dated November, 1989;

as detailed in "A HEALTH CARE QUALITY IMPROVEMENT SYSTEM FOR MEDICAID COORDINATED CARE", U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Health Care Financing Administration Medicaid Bureau, December 23, 1992.

SECTION I

GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF ORGANIZATIONS CONTRACTING WITH TENNCARE

STANDARD I: WRITTEN QMP DESCRIPTION

The organization has a written description of its QMP. This written description meets the following criteria:

A. Goals and Objectives - The written description contains a detailed set of QM objectives which are developed annually and include a timetable for implementation and accomplishment.

B. Scope -

1. The scope of the QMP is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service, such as and including: availability, accessibility, coordination, and continuity of care.

2. The QMP methodology provides for review of the entire range of care provided by the organization, by assuring that all demographic groups, care settings, (e.g., surgery centers, ambulatory care including that provided in private practice offices) and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.

C. Specific Activities - The written description specifies quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities are clearly identified and are appropriate.

D. Continuous Activity - The written description provides for continuous performance of the activities, including tracking of issues over time.

E. Provider Review - The QMP provides for:

1. Review by dentists and other dental professionals of the process followed in the provision of dental services; and

2. Feedback to dental professionals and organization staff regarding performance and patient results.

F. Focus on Dental Outcomes - The QMP methodology addresses dental outcomes to the extent consistent with existing technology.

G. The QMP guidelines must be disseminated to all affected providers and, upon request, to enrollees and potential enrollees.

STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT & IMPROVEMENT

The QMP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to members, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

The QMP has written guidelines for its quality of care studies and related activities which include:

A. Specification of dental services delivery areas to be monitored -

1. The monitoring and evaluation of care reflects the population served by the Contractor in terms of age groups, disease categories, and special risk status.

2. For the TennCare population, the QMP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These may be taken from among those identified by the Centers for Medicare and Medicaid (CMS) (formerly Health Care Financing Administration/HCFA), or other sources as deemed necessary by TennCare.

3. At its discretion and/or as required by TennCare, the Contractor's QMP also monitors and evaluates other important aspects of care and services.

B. Use of Quality Indicators -

Quality indicators are measurable variables relating to a specified dental services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area.

1. The Contractor identifies and uses quality indicators including those specified in Clinical and Health Services Delivery Areas of Concern that are objective, measurable, and based on current knowledge and clinical experience.

2. For the priority areas selected by the state from the CMS Bureau's list of priority demtal services delivery areas of concern, or other sources as deemed necessary by the State, the organization shall monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the CMS Bureau or by the State.

3. Methods and frequency of data collection are appropriate and sufficient to detect need for program change.

C. Use of Clinical Care Standards/Practice Guidelines -

1. The QMP studies and other activities monitor quality of care against dental service delivery standards or practice guidelines specified for each area identified in "STANDARD II, A," above.

2. The standards/guidelines are based on reasonable scientific evidence and are developed or reviewed by plan providers.

3. The standards/guidelines focus on the process and outcomes of dental care delivery, as well as access to care.

4. A mechanism is in place for continuously updating the standards/guidelines.

5. The standards/guidelines shall be included in provider manuals developed for use by dental providers or otherwise disseminated to providers as they are adopted.

6. The standards/guidelines address preventive dental services.

7. Standards/guidelines are developed for the full spectrum of populations enrolled in the plan.

8. The QMP shall use these standards/guidelines to evaluate the quality of care provided

by the Contractor's providers, whether the providers are organized in groups or as individuals.

D. Analysis of Clinical Care and Related Services -

1. Appropriate clinicians monitor and evaluate quality through review of individual cases where there are questions about care, and through studies analyzing patterns of clinical care and related services. For quality issues identified in the QMP's targeted clinical areas, the analysis includes the identified quality indicators and uses clinical care standards or practice guidelines.

2. Multidisciplinary teams are used, where indicated, to analyze and address systems issues.

E. Implementation of Remedial/Corrective Actions -

The QMP includes written procedures for taking appropriate remedial action whenever, as determined under the QMP, inappropriate or substandard services are furnished, or services that should have been furnished were not.

These written remedial/corrective action procedures include:

1. specification of the types of problems requiring remedial/corrective action;

2. specification of the person(s) or body responsible for making the final determinations regarding quality problems;

3. specific actions to be taken;

4. provision of feedback to appropriate dental professionals and staff;

5. the schedule and accountability for implementing corrective actions;

6. the approach to modifying the corrective action if improvements do not occur;

7. procedures for terminating the affiliation with the dental professional.

F. Assessment of Effectiveness of Corrective Actions -

1. As actions are taken to improve care, there is monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

2. The Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective.

G. Evaluation of Continuity and Effectiveness of the QMP -

1. The Contractor conducts a regular examination of the scope and content of the QMP to ensure that it covers all types of services in all settings, as specified in STANDARD I-B-2.

2. At the end of each year, a written report on the QMP is prepared, which addresses: QM studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and

recommendations for corrective action; and an evaluation of the overall effectiveness of the QMP.

3. There is evidence that QM activities have contributed to reasonable improvements in the care delivered to members such that the level of care provided is that which is recognized as acceptable professional practice in the respective community in which particular providers practice.

STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY

The Governing Body of the organization is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the Contractor. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

A. Oversight of QMP - There is documentation that the Governing Body has approved the overall QMP and an annual QM plan.

B. Oversight Entity - The Governing Body has formally designated an accountable entity or entities within the organization to provide oversight of QM, or has formally decided to provide such oversight as a committee of the whole.

C. QMP Progress Reports - The Governing Body routinely receives written reports from the QMP describing actions taken, progress in meeting QM objectives, and improvements made.

D. Annual QMP Review - The Governing Body formally reviews on a periodic basis (but no less frequently than annually) a written report on the QMP which includes: studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services rendered, to assess acceptability.

E. Program Modification - Upon receipt of regular written reports from the QMP delineating actions taken and improvements made, the Governing Body takes action when appropriate and directs that the operational QMP be modified on an ongoing basis to accommodate review findings and issues of concern within the organization. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to Quality Monitoring/Improvement.

STANDARD IV: ACTIVE QM COMMITTEE

The QMP delineates an identifiable structure responsible for performing QM functions within the organization. This committee or other structure has:

A. Regular Meetings - The structure/committee meets on a regular basis with specified frequency to oversee QMP activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent than quarterly.

B. Established parameters for Operating - The role, structure and function of the structure/committee are specified.

C. Documentation - There are records documenting the structure's/committee's activities, findings, recommendations and actions.

D. Accountability - The QMP committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.

E. Membership - There is active participation in the QM committee from dental plan providers, who are representative of the composition of the plan's providers and shall include as a non-voting member, a representative of the TennCare Office of the Dental Director.

STANDARD V: QMP SUPERVISION

There is a designated senior executive who is responsible for program implementation. The organization's Dental Director has substantial involvement in QM activities.

STANDARD VI: ADEQUATE RESOURCES

The QMP has sufficient material resources, and staff with the necessary education, experience, or training, to effectively carry out its specified activities.

STANDARD VII: PROVIDER PARTICIPATION IN THE QMP

A. Participating dentists are kept informed about the written QM plan.

B. The organization includes in all its provider contracts and employment agreements, for both dentists and non-dentist providers, a requirement securing cooperation with the QMP.

C. Contracts specify that hospitals and other Contractors will allow the Contractor access to the medical records of its members.

STANDARD VIII: DELEGATION OF QMP ACTIVITIES

The Contractor remains accountable for all QMP functions, even if certain functions are delegated to other entities. If the Contractor delegates any QM activities to Contractors:

A. There is a written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the Contractor.

B. The Contractor has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

C. There is evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and regular specified reports.

STANDARD IX: CREDENTIALING AND RECREDENTIALING

The QMP contains the following provisions to determine whether dentists and other dental care professionals, who are licensed by the State and who are under contract to the organization, are qualified to perform their services.

A. Written Policies and Procedures - The Contractor has written policies and procedures for the credentialing process, which includes the organization's initial credentialing of practitioners, as well as its subsequent re-credentialing, re-certifying and/or reappointment of practitioners.

B. Oversight by Governing Body - The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.

C. Credentialing Entity - The plan designates a credentialing committee or other peer review body which makes recommendations regarding credentialing decisions.

D Scope – The Contractor shall identify those practitioners to be credentialed that fall under its scope of authority and action. Practitioners to be credentialed shall include, at a minimum, all dentists included in the Contractor's literature for members, as an indication of those practitioners whose service to member is contracted or anticipated. The Contractor shall submit a plan to the TennCare Bureau outlining the process which it shall employ to ensure appropriate and timely credentialing of all providers participating in the dental plan. In all contracts with health care professionals, the Contractor must comply with the requirements specified in the Balanced Budget Act of 1997, Section 438.214.

E. Process - The initial credentialing process obtains and reviews verification of the following information, at a minimum:

1. Primary Verification

   a. the practitioner holds a current valid license to practice within the State;

   b. valid DEA or CDS certificate, as applicable;

   c. confirmation of highest level of education and training received;

   d. professional liability claims history (past five (5) years) from the National Practitioner Data Bank and the State Board of Dentistry; and

   e. any sanctions imposed by Medicare, Medicaid, TennCare and/or the Tennessee Board of Dentistry.

   f. good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)

   g. any revocation or suspension of a state license, DEA/BNDD number, or CDS certificate.

2. Secondary Verification (self reported)

   a. work history – past five (5) years. Verbal explanation for gaps greater than six (6) months, written explanation for gaps greater than one (1) year;

   b. the practitioner holds current, adequate malpractice insurance according to the plan's policy;

   c. any curtailment or suspension of medical staff privileges (other than for incomplete medical records);

d. any censure by the State or County Dental Association;

e. the application process includes a statement by the applicant and an investigation of said statement regarding:

(1) any physical or mental health problems that may affect current ability to provide dental care;

(2) any history of chemical dependency/substance abuse;

(3) history of loss of license and/or felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity; and

(5) current malpractice coverage and limits; and

(6) an attestation to correctness/completeness of the application.

3. Any information obtained will be evaluated to determine whether any or all of said information would impact a practitioner's ability to conform to the standards established by the Contractor in accordance with the requirements placed on the Contractor by TennCare per Section A.1.1. of the Agreement. The Contractor may decide, based on information obtained in the credentialing process, not to contract with a provider.

4. There is an initial visit to each dentist's office, including documentation of a structured review of the site and dental record keeping practices to ensure conformance with the Contractor's standards.

F. Recredentialing - A process for the periodic reverification of clinical credentials (recredentialing, reappointment, or recertification) is described in the organization's policies and procedures.

1. There is evidence that the procedure is implemented at least every three years.

2. There is verification of State licensure at least every three years,

3. The Contractor conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all dentists to decide whether to renew the participating dentist agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in "F-1" through "F-2.c" above, and item "F-2.g" as well.

4. The recredentialing, recertification or reappointment process also includes review of data from:

a. member complaints;

b. results of quality reviews;

c. utilization management;

d. member satisfaction surveys; and

e. reverification of hospital privileges and current licensure.

G. Reporting Requirement - There is a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.

H. Appeals Process - There is a provider appellate process for instances where the Contractor chooses to reduce, suspend or terminate a practitioner's privileges with the organization.

STANDARD X: ENROLLEE RIGHTS AND RESPONSIBILITIES

The Contractor demonstrates a commitment to treating members in a manner that acknowledges their rights and responsibilities.

A. Written Policy on Enrollee Rights - The organization has a written policy that recognizes the following rights of members:

1. to be treated with respect, and recognition of their dignity and need for privacy;

2. to be provided with information about the organization, its services, the practitioners providing care, and members' rights and responsibilities;

3. to be able to choose dentists within the limits of the plan network, including the right to refuse care from specific practitioners;

4. to participate in decision-making regarding their dental care;

5. to voice complaints or appeals about the organization or care provided;

6. to be guaranteed the right to request and receive a copy of his or her dental records, and to request that they be amended or corrected as specified in 45 CFR part 164;

7. to be guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

8. to be free to exercise his or her rights, and that that exercise of those rights does not adversely affect the way the DBM and it’s providers or the State agency treat the enrollee.

9. to be guaranteed the right to receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee’s condition and ability to understand.

B. Written Policy on Enrollee Responsibilities - The organization has a written policy that addresses members' responsibility for cooperating with those providing dental care services. This written policy addresses members' responsibility for:

1. providing, to the extent possible, information needed by professional staff in caring for the member; and

2. following instructions and guidelines given by those providing dental care services.

C. Communication of Policies to Providers - A copy of the organization’s policies on members' rights and responsibilities is provided to all participating providers.

D. Communication of Policies to Enrollees/Members - Upon enrollment, members are provided a written statement that includes information on the following:

1. rights and responsibilities of members;

2. benefits and services included and excluded as a condition of membership, and how to obtain them, including a description of:

    a. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to services obtained outside the system; and

    b. the procedures for obtaining out-of-area coverage;

3. provisions for after-hours and emergency coverage;

4. the organization's policy on referrals for specialty care;

5. charges to members, if applicable, including:

    a. policy on payment of charges; and

    b. co-payment and fees for which the member is responsible;

6. procedures for notifying those members affected by the termination or change in any benefits, services, or service delivery office/site;

7. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

8. procedures for changing practitioners;

9. procedures for voicing complaints and/or appeals and for recommending changes in policies and services.

E. Enrollee/Member Complaint and Appeal Procedures - The organization has a system(s), linked to the QMP, for resolving members' complaints and appeals. This system includes:

1. procedures for registering and responding to complaints and appeals in a timely fashion (organizations should establish and monitor standards for timeliness);

2. documentation of the substance of complaints or appeals, and actions taken;

3. procedures to ensure a resolution of the complaint or appeal;

4. aggregation and analysis of complaint and appeal data and use of the data for quality improvement; and

5. an appeal process for adverse actions.

F. Enrollee/Member Suggestions - Opportunity is provided for members to offer suggestions for changes in policies and procedures.

G. Steps to Assure Accessibility of Services - The Contractor takes steps to promote accessibility of services offered to members. These steps include:

1. the points of access to dental services, specialty care, and hospital or ambulatory surgical center services are identified for members; and

2. at a minimum, members are given information about:

    a. how to obtain services during regular hours of operations;

    b. how to obtain emergency and after-hours care; and

c. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care.

H. Written Information for Members -

1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood.

2. Written information is available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10 percent of a plan's population or 3,000 enrollees, whichever is less. All vital documents and the member handbook is available in Spanish. All vital documents are also available to Limited English Proficiency groups identified by TennCare that constitutes five percent (5%) of the TennCare population or 1,000 enrollees, whichever is less.

I. Confidentiality of Patient Information - The organization acts to ensure that the confidentiality of specified patient information and records is protected.

1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records.

2. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the dental care organization.

3. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:

a. it is required by law;

b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or

c. it is necessary in compelling circumstances to protect the health or safety of an individual.

4. Any release of information in response to a court order is reported to the patient in a timely manner.

5. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.

J. Treatment of Minors - The Contractor has written policies regarding the appropriate treatment of minors.

K. Assessment of Member Satisfaction - The Contractor conducts periodic surveys of member satisfaction with its services.

1. The surveys include content on perceived problems in the quality, availability, and accessibility of care.
2. As a result of the surveys, the Contractor:

a. identifies and investigates sources of dissatisfaction;

b. outlines action steps to follow-up on the findings; and

c. informs providers of assessment results.

3. The Contractor reevaluates the effects of the above activities.

STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY

The Contractor has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and member service lines). Performance on these dimensions of access are assessed against the standards.

STANDARD XII: STANDARDS FOR FACILITIES

A. The Contractor maintains standards for facilities in which patients receive ambulatory care. These standards address:

1. compliance with existing State and local laws regarding safety and accessibility;

2. availability of emergency equipment;

3. storage of drugs; and

4. inventory control for expired medications.

B. A requirement for adherence to these standards is contained in all of the Contractor's provider contracts.

STANDARD XIII: DENTAL RECORD STANDARDS

A. Accessibility and Availability of Dental Records -

1. The organization shall include provisions in provider contracts for appropriate access to the dental records of its enrollees for purposes of quality reviews conducted by the Secretary, TennCare agencies, or agents thereof.

2. Records are available to dental care practitioners at each encounter.

B. Recordkeeping - Dental records may be on paper or electronic media. The Contractor takes steps to promote maintenance of dental records in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review as follows:

1. Dental Record Standards - The Contractor sets standards for dental records. These standards shall, at a minimum, include requirements for:

a. Patient Identification Information - Each page in the record contains the patient's name or patient ID number.

b. Personal/biographical Data - Personal/biographical data includes: age; sex; address; employer; home and work telephone numbers; and marital status.

c. Entry Date - All entries are dated.

d. Provider Identification - All entries are identified as to author.

e. Legibility - The record is legible to someone other than the writer. Any record judged illegible by one reviewer should be evaluated by a second reviewer. If still illegible, it shall be considered deficient.

f. Allergies - Medication allergies and adverse reactions are prominently noted on the record. Absence of allergies (no known allergies - NKA) is noted in an easily recognizable location.

g. Past Medical History - (for patients seen three or more times) Past medical history is easily identified including serious accidents, operations, illnesses. For children, past medical history relates to prenatal care and birth.

h. Immunizations - (for pediatric records ages 12 and under) There is a completed immunization record or a notation that immunizations are up-to-date.

i. Diagnostic information.

j. Medication information.

k. Identification of current problems - Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record.

l. Smoking/ETOH/Substance Abuse - (For patients 12 years and over and seen three or more times) Notation concerning cigarettes and alcohol use and substance abuse is present. Abbreviations and symbols may be appropriate.

m. Referrals and Results Thereof.

n. Emergency Care.

2. Patient Visit Data - Documentation of individual encounters must provide adequate evidence of, at a minimum:

a. History and Physical Examination - Appropriate subjective and objective information is obtained for the presenting complaints.

b. Plan of Treatment.

c. Diagnostic Tests.

d. Therapies and other Prescribed Regimens.

e. Follow-up - Encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months, or PRN. Unresolved problems from previous visits are addressed in subsequent visits.

f. Consultations, Referrals and Specialist Reports - Notes from any consultations are in the record. Consultation, lab and x-ray reports filed in the chart have the ordering dentist's/physician's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

g. All Other Aspects of Patient Care, Including Ancillary Services.

C. Record Review Process -

1. The Contractor has a record review process to assess the content of dental records for legibility, organization, completion and conformance to its standards.

2. The record assessment system addresses documentation of the items listed in B, above.

STANDARD XIV: UTILIZATION REVIEW

A. Written Program Description - The Contractor has a written utilization management program description which includes, at a minimum, procedures to evaluate medical necessity, criteria used, information sources and the process used to review and approve the provision of medical services.

B. Scope - The program has mechanisms to detect underutilization as well as overutilization.

C. Preauthorization and Concurrent Review Requirements - For organizations with preauthorization or concurrent review programs:

1. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantative coverage limits, whether explicit or defacto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her history.

2. Preauthorization and concurrent review decisions are supervised by qualified dental professionals.

3. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentists as appropriate.

4. The reasons for decisions are clearly documented and available to the member.

5. There are well-publicized and readily available appeals mechanisms for both providers and patients.

6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation.

7. There are mechanisms to evaluate the effects of the program using data on member satisfaction, provider satisfaction or other appropriate measures.

8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.

STANDARD XVI: QMP DOCUMENTATION

A. Scope - The organization shall document that it is monitoring the quality of care across all services and all treatment modalities, according to its written QMP.

B. Maintenance and Availability of Documentation - The Contractor must maintain and make available to the State, and upon request to the Secretary, studies, reports, protocols, standards, worksheets, minutes, or such other documentation as may be appropriate, concerning its QM

activities and corrective actions.

STANDARD XVII: COORDINATION OF QM ACTIVITY WITH OTHER MANAGEMENT ACTIVITY

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QM activity, are documented and reported to appropriate individuals within the organization and through the established QM channels.

A. QM information is used in recredentialing, recontracting and/or annual performance evaluations.

B. QM activities are coordinated with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member complaints and grievances.

C. There is a linkage between QM and the other management functions of the dental plan such as:

1. network changes;

2. benefits redesign;

3. medical management systems (e.g., precertification);

4. practice feedback to dentists;

5. patient education; and

6. member services.

CLINICAL AND HEALTH SERVICES DELIVERY AREAS OF CONCERN, QUALITY INDICATORS, AND CLINICAL PRACTICE GUIDELINES FOR QUALITY IMPROVEMENT IN TennCare ORGANIZATIONS

I. INTRODUCTION

The section entitled "GUIDELINES FOR INTERNAL QUALITY MONITORING PROGRAMS OF ORGANIZATIONS CONTRACTING WITH TennCare" (the Guidelines) describes the activities which TennCare requires as standards for internal quality assurance programs (QMPs). The Guidelines, in part, call for TennCare Contractors responsible for administering medical/dental services to implement a systematic process of quality assessment and improvement by which the care delivered to enrollees is monitored, evaluated, and continually improved to comply with the Guidelines for internal QMPs.

II. QUALITY OF CARE STUDIES

An organization cannot monitor the care delivered to every enrollee each time he or she requires health care. Such an attempt would be beyond the organization's and State and Federal resources. As an alternative, the organization shall select certain aspects of care to monitor over a specified time period. Over subsequent time periods, monitoring will be repeated in that area to detect patterns of care over time, and new areas will be selected for initial study. Such monitoring takes place through focused quality of care studies.

Focused quality of care studies are detailed investigations of certain aspects of health care services which are designed to answer defined questions about the quality and appropriateness of care and point the way to how that care can be improved. Such focused studies are superior to random or unfocused

record reviews because they provide information about care in the aggregate as opposed to information about the care received by a limited number of enrollees.

III. CLINICAL AND HEALTH SERVICES DELIVERY AREAS OF CONCERN:

Item II. A. in the "Guidelines for Internal Quality Monitoring Programs of Organizations Contracting with TennCare", states in part:

"The QMP has written guidelines for its quality of care studies...which shall include:

1. specification of clinical or health services delivery area to be monitored -

    a. The monitoring and evaluation of care reflects the population served by the organization in terms of age groups, disease categories, and special risk status.

    b. For the TennCare population, the QMP monitors and evaluates, at a minimum, care and services in certain priority areas of concern selected by the State. These may be taken from among those identified by HCFA's Medicaid Bureau, or other sources as deemed necessary by TennCare."

A review of the literature and discussion with health authorities pertaining to the prevalence and significance of health concerns has lead to the identification of the following priority clinical and health services delivery areas of concern. With the exception of the identification of pregnancy, childhood immunizations, and continuity of care, as required for continuous monitoring and evaluation by plans, the areas listed below are <u>not</u> listed in any order of priority.

Clinical areas of concern:

Dental Screening and Services for Individuals less than 21 Years of Age.

Health Services Delivery Areas of Concern:

1. Continuity/Coordination of Care (Required continual monitoring with quarterly reporting)

2. Access to Care

3. Utilization of Services

4. Health Education

5. Emergency Services

One of the health services delivery areas of concern (continuity/coordination of care) is required for <u>continuous</u> evaluation and study if applicable to the patient population. In addition, it is required that Contractor select on a quarterly basis, at least one additional area of concern to study. This may be a follow-up of a previously performed evaluation or a new study. Areas of concern may come from the above noted list, or at the discretion of the Contractor, from another source. In addition, the Contractor will perform such studies as the State may direct. Effective July 1, 2001, all entities contracted with TennCare for the provision of services to children are required to begin a continuous evaluation and study of access to EPSDT services for individuals less than twenty-one (21) years of age. A copy of the study design shall be submitted to TennCare for review and approval within ninety (90) days of the effective date of this Agreement.

IV. CLINICAL PRACTICE GUIDELINES/STANDARDS:

The identification of areas needing improvement and the creation of a baseline for future assessment necessitates specifying goals or standards for health services to which care actually delivered can be compared. Item II. C. in the Guidelines states, in part, that:

> "a. The QMP studies and other activities monitor quality of care against clinical or health services delivery standards or practice guidelines specified for each clinical or health services delivery area identified in II. A., above...".

Clinical care standards, practice guidelines, practice options and practice advisories are all types of "practice parameters". Practice parameters are recommendations or an agreed upon set of principles for the delivery of certain types or aspects of dental care. They are promulgated by authoritative bodies such as professional associations or ad-hoc "expert committees". Because professional judgment may often vary, there can frequently be more than one set of practice parameters addressing the same topic. However, the vast majority of dental professional organizations endorse the use of practice parameters in improving the quality of dental care.

For this reason, the Guidelines recommend monitoring quality of care using clinical care standards or practice guidelines for each clinical or health services delivery area selected by the Contractor or State for study.

For other clinical or health services delivery areas to be studied by the Contractor as part of its agreement with TennCare, the Contractor and TennCare shall agree upon the clinical practice standards or practice guidelines which are to be utilized by the Contractor in its evaluation of care. If TennCare wishes the Contractor to evaluate care in an area in which the organization has not already adopted a set of practice guidelines, the organization and TennCare will agree upon usage of existing clinical practice standards/practice guidelines based upon those already developed by authoritative bodies.

V. QUALITY INDICATORS:

In conducting quality of care studies, the organization assesses care through the use of objective indicators. Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or to monitor the process or outcome of care delivered in that clinical area. Item II. B. of the Guidelines states:

> "a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience...
>
> b. For the priority areas selected by the State from CMS Bureau's list of priority clinical and health services delivery areas of concern, or other sources as deemed necessary by the State, the Contractor shall monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by CMS Bureau or the State."

TennCare and the Contractor shall mutually determine clinical indicators to be monitored for each clinical or health services delivery area of concern. Because of its importance, continuity/coordination of care indicators shall be monitored by the organization on a continuous basis (as opposed to on a one time basis) and reported to TennCare on a Quarterly basis. At its own discretion or as directed by TennCare, the Contractor should identify, based on clinical practice guidelines described above, additional clinical indicators to be monitored for the additionally selected clinical conditions.

In addition, TennCare shall use individual encounter data and other required reports to monitor performance on an on-going basis.

ATTACHMENT V
Definitions

The terms used in this Agreement shall be given the meaning used in the Rules and Regulations of the Bureau of TennCare. However, the following terms when used in this Agreement, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between the Definitions, Addendum, Attachments, and other Sections of this Agreement, the language in Sections A through E of this Agreement shall govern.

1. Administrative Cost – All costs to the Contractor related to the administration of this Agreement. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Agreement (including, but not limited to, claims processing, marketing, postage, personnel, rent) are considered to be an “administrative cost”.

2. Administrative Services Fee - The per member per month amount that the Contractor will charge for provision of the services outlined in this Agreement.

3. Adverse Action - Any action taken by the Contractor to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits.

4. Appeal Procedure - The process to resolve an enrollee’s right to contest verbally or in writing, any adverse action taken by the Contractor to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omissions of the Contractor which impair the quality, timeliness or availability of such benefits. The appeal procedure shall be governed by TennCare rule 1200-13-12-.11 and any and all applicable court orders. Complaint shall mean an enrollee’s right to contest any other action taken by the Contractor or service provider other than those that meet the definition of an adverse action.

5. Benefits - A schedule of health care services to be delivered to enrollees covered in the Contractor's plan developed pursuant to Attachment II of this Agreement.

6. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care; and for monitoring the continuity of patient care services.

7. CFR - Code of Federal Regulations

8. Clarification –A revision that is not a change or amendment to the Agreement but is only a revision in language to more accurately reflect the existing agreement between the parties. Such clarification is a housekeeping item only, and as such, bears an effective date of the Agreement.

9. Clean claim - A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.

10. CMS - Centers for Medicare and Medicaid Services (formerly HCFA).

11. Community Service Area - Community Service Area (CSA) shall mean one (1) or more counties in a defined geographical area in which the Contractor is authorized to enroll providers and serve TennCare members.

    The following geographical areas shall constitute the twelve (12) Community Service Areas in Tennessee:

Northwest CSA	-	Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll and Benton
Southwest CSA	-	Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester and McNairy
Shelby CSA	-	Shelby County
Mid-Cumberland CSA	-	Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson and Rutherford
Davidson CSA	-	Davidson County
South Central CSA	-	Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore
Upper Cumberland CSA	-	Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren and Van Buren
Southeast CSA	-	Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley and Marion
Hamilton CSA	-	Hamilton County
East Tennessee CSA	-	Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon and Roane
Knox CSA	-	Knox County
First Tennessee CSA	-	Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter and Johnson

12. Covered Service - See Benefits at A.1.2 of the Agreement

13. Cultural Competence - the level of knowledge-based skills required to provide effective clinical care to patients of particular ethnic or racial groups.

14. DBM – Dental Benefits Manager.

15. Disenrollment - The discontinuance of a member's entitlement to receive covered services under the terms of this Agreement, and deletion from the approved list of members furnished by TennCare to the Contractor.

16. Eligible Person - Any person certified by TennCare as eligible to receive services and benefits under the TennCare Program.

17. Emergency Services – means covered inpatient and outpatient services that are: furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an emergency medical condition.

18. Emergency Medical Condition – means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of

the woman and her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

19. Enrollee - A Medicaid recipient or Medicaid Waiver recipient who is currently enrolled in an MCO, PIHP, PAHP or PCCM in a given managed care program.

20. Enrollee Month – A month of health care coverage for the TennCare eligible enrolled in a Dental Plan.

21. Enrollment - The process by which a person becomes a member of the Contractor's plan through the TennCare Bureau.

22. EPSDT - The Early, Periodic Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. EPSDT services shall mean:

    (a) Screening in accordance with professional standards, interperiodic screenings, and diagnostic services to determine the existence of physical or mental illnesses or conditions of TennCare enrollees under age twenty-one (21) and

    (b) Health care, treatment, and other measures, described in 42 U.S.C. § 1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

23. Facility – Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this Agreement; or (b) maintained by a subcontractors or provider to provide services on behalf of the Contractor.

24. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment for defined services.

25. FTE - Full time equivalent position.

26. Grand Region – A defined geographical region that includes specified Community Service Areas in which a Contractor is authorized to enroll providers and serve TennCare members. The following Community Service Areas constitute the three (3) Grand Regions in Tennessee:

East Grand Region	Middle Grand Region	West Grand Region
First Tennessee	Upper Cumberland	Northwest
East Tennessee	Mid Cumberland	Southwest
Knox	Davidson	Shelby
Southeast Tennessee	South Central	Hamilton

27. Handicapping Malocclusion – for the purposes of determining eligibility for orthodontia shall mean the presence of abnormal dental development that has at least one of the following:

- A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.
- The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.
- Palatal tissue laceration from a deep impinging overbite where lower incisor teeth contact palatal mucosa. This does not include occasional biting of the cheek.

Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Anecdotal information is represented by statements that are not supported by professional progress notes that the patient has difficulty with eating,

chewing, or speaking. These conditions may be caused by other medical conditions in addition to the malalignment of the teeth.

28. Health Maintenance Organization (HMO) - An entity certified by the Department of Commerce and Insurance under applicable provisions of Tennessee Code Annotated (T.C.A.) Title 56, Chapter 32.

29. Immediate Eligibility – Temporary eligibility granted to a child upon entering into DCS Custody in order to give children in DCS adequate access to medical services, including EPSDT, until a final determination can be made on their TennCare eligibility.

30. Managed Care Organization ("MCO") **-** An HMO which participates in the TennCare Program.

31. Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member.

32. Medically Necessary **-** Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness, disease, or injury and which are:

    a. Consistent with the symptoms or diagnosis and treatment of the enrollee's condition, disease, ailment or injury, and

    b. Appropriate with regard to standards of good dental practice; and

    c. Not solely for the convenience of an enrollee, dentist, institution or other provider; and

    d. The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and

    e. When applied to enrollees under 21 years of age who are eligible for EPSDT, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

33. Member - A person who is eligible for the Contractor's plan under the provisions of this Agreement with TennCare. (See Enrollee, also).

34. NAIC – National Association of Insurance Commissioners.

35. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or through the Contractor or any of its subcontractors pursuant to the Agreement between the Contractor and TennCare.

36. Office of the Inspector General - A Unit established to help prevent, identify and investigate fraud and abuse within the healthcare system, most notably the TennCare system.

37. Out-of-Plan Services - Services provided by a non-contract provider.

38. Potential Enrollee – A Medicaid recipient or Medicaid Waiver recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, and PCCM.

39. Presumptive Eligible - Temporary eligibility granted to a pregnant woman whose family income is at or below a specified percentage of the federal poverty level in order for the woman to receive prenatal care services.

40. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.

41. Primary Care Provider - A primary care physician or registered professional nurse or physician assistant practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.

42. Prior Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.

43. Program Integrity - The Program Integrity unit is responsible for assisting with the prevention, identification and investigation of fraud and abuse within the health care system.

44. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by TennCare which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Contractor.

45. Provider Agreement - An agreement between an MCO or DBM and a provider or an MCO's or DBM's subcontractors and a provider of oral health care services which describes the conditions under which the provider agrees to furnish covered services to the MCO's or DBM's members.

46. Quality Improvement (QI) - The ongoing process of responding to data gathered through quality monitoring efforts, in such a way as to improve the quality of health care delivered to individuals. This process necessarily involves follow-up studies of the measures taken to effect change in order to demonstrate that the desired change has occurred.

47. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical knowledge.

48. Service Location - Any location at which an enrollee obtains any oral health care service covered by the Contractor pursuant to the terms of this Agreement.

49. Service Site - The locations designated by the Contractor at which members shall receive oral health treatment and preventive services.

50. Services - The benefits described in Section A.1.2.

51. Shall - Indicates a mandatory requirement or a condition to be met.

52. Specialty Services – Includes Pediatric Dentistry, Oral Surgery, Endodontics and Orthodontics.

53. State - State of Tennessee.

54. Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Agreement, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this Agreement.

Agreements to provide covered services as described in Section A.1.2. of this Agreement shall be considered Provider Agreements and governed by Section A.11 of this Agreement.

55. SubContractor - Any organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to TennCare under the terms of this Agreement.

56. TennCare **-** The State of Tennessee and any entity authorized by statute or otherwise to act on behalf of the State of Tennessee in administering and/or enforcing the terms of this Agreement. Such entity(ies) may include, but are not limited to, the TennCare Bureau, the Department of Health, the Department of Finance and Administration, the Department of Mental Health and Mental Retardation, the TennCare Division within the Tennessee Department of Commerce and Insurance and the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit.

57. TennCare Medicaid Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through Medicaid eligibility criteria as described in the Medicaid/TennCare Rules and Regulations.

58. TennCare Standard Enrollee – an enrollee who qualifies and has been determined eligible for benefits in the TennCare program through eligibility criteria designated as “TennCare Standard”.

59. Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU) – The State agency responsible for the investigation of provider fraud and abuse in the State Medicaid Program.

60. Third Party Resource - Any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care of the enrollee.

61. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party.

ATTACHMENT VI

Provider Reimbursement Fee Schedule

The procedure codes and fees listed below **do not** represent a listing of authorized, TennCare covered services for which the Contractor is responsible to provide under the terms of the Agreement. This listing is provided in order to address required reimbursement amounts for services provided by the Contractor subject to the terms of this Agreement. Services for which the Contractor is obligated to cover in accordance with this Agreement that are not identified in the procedure codes and fees listed below shall be submitted to TennCare in accordance with Section A.22.2.a of this Agreement.

PROC	NAME OF PROCEDURE	PROVIDER FEE
DIAGNOSTIC		
Clinical Oral Examinations		
D0120	Periodic oral evaluation	$ 24.00
D0150	Comprehensive oral evaluation	$ 35.00
Radiographs		
D0210	Intraoral – complete series (including bitewings)	$ 75.00
D0220	Intraoral - periapical - lst film	$ 15.00
D0230	Intraoral – periapical - each additional film	$ 12.00
D0270	Bitewing – single film	$ 14.00
D0272	Bitewings – two films	$ 22.00
D0274	Bitewings – four films	$ 34.00
D0330	Panoramic film	$ 60.00
D0340	Cephalometric film	$ 60.00
PREVENTIVE		
Dental Prophylaxis		
D1110	Prophylaxis – adult	$ 45.00
D1120	Prophylaxis – child	$ 35.00
Topical Fluoride Treatment (Office Procedure)		
D1203	Topical application of fluoride (prophylaxis not included) – child	$ 20.00
D1204	Topical application of fluoride (prophylaxis not included) – adult	$ 20.00
Other Preventive Services		
D1351	Sealant – per tooth	$ 28.00
Space Maintenance (Passive Appliances)		
D1510	Space maintainer – fixed – unilateral	$ 175.00
D1515	Space maintainer – fixed – bilateral	$ 253.00
D1550	Recementation of space maintainer	$ 38.00
RESTORATIVE		
Amalgam Restorations (Including polishing)		
D2140	Amalgam – 1 surface – primary	$ 58.00
D2150	Amalgam – 2 surface – primary	$ 70.00
D2160	Amalgam – 3 surface – primary	$ 82.00
D2140	Amalgam – 1 surface – permanent	$ 61.00
D2150	Amalgam – 2 surface – permanent	$ 76.00
D2160	Amalgam – 3 surface – permanent	$ 88.00

D2161	Amalgam – 4+ surface – permanent	$ 101.00
Resin Restorations		
D2330	Composite – I surface – anterior– primary	$ 75.00
D2331	Composite – 2 surfaces – anterior– primary	$ 90.00
D2332	Composite – 3 surfaces – anterior– primary	$ 108.00
D2335	Composite – 4 or more surfaces or involving incisal angle (anterior) – primary	$ 143.00
D2330	Composite – I surface – anterior– permanent	$ 75.00
D2331	Composite – 2 surfaces – anterior– permanent	$ 90.00
D2332	Composite – 3 surfaces – anterior– permanent	$ 108.00
D2335	Composite – 4 or more surfaces or involving incisal angle (anterior) – permanent	$ 143.00
D2390	Composite – crown, anterior – primary	$ 165.00
D2390	Composite – crown, anterior – permanent	$ 170.00
D2391	Composite – 1 surface, posterior – primary	$ 71.00
D2392	Composite – 2 surfaces, posterior – primary	$ 89.00
D2393	Composite – 3 or more surfaces, posterior, primary	$ 112.00
D2391	Composite – 1 surface, posterior – permanent	$ 82.00
D2392	Composite – 2 surfaces, posterior – permanent	$ 100.00
D2393	Composite – 3 surfaces, posterior – permanent	$ 125.00
D2394	Composite – 4 or more surfaces, posterior – permanent	$ 173.00
Crowns – Single Restorations Only		
D2740	Crown – porcelain/ceramic substrate	$ 600.00
D2750	Crown – porcelain fused to high noble metal	$ 575.00
D2751	Crown – porcelain fused to predominately base metal	$ 544.00
D2752	Crown – porcelain fused to noble metal	$ 560.00
Other Restorative Services		
D2920	Re-cement crown	$ 50.00
D2930	Prefabricated stainless steel crown – primary tooth	$ 125.00
D2931	Prefabricated stainless steel crown – permanent tooth	$ 157.00
D2932	Prefabricated Resin crown	$ 165.00
D2933	Stainless steel crown, with resin window	$ 174.00
D2940	Sedative filling	$ 53.00
D2950	Core build up, including any pins	$ 130.00
D2951	Pin retention - per tooth, in addition to restoration	$ 36.00
D2952	Cast post and core, in addition to crown	$ 200.00
D2954	Prefabricated post and core	$ 170.00
ENDODONTICS		
Pulpotomy		
D3220	Therapeutic pulpotomy (excluding final restoration)	$ 95.00
D3221	Gross pulpal debridement – primary and permanent	$ 98.00
Endodontic Therapy on Primary Teeth		
D3230	Pulpal therapy, anterior – primary	$ 98.00
D3240	Pulpal therapy, posterior – primary	$ 98.00
Endodontic Therapy (including treatment plan, clinical procedures, and follow-up care)		
D3310	Root canal – Anterior (excluding final restoration)	$ 355.00
D3320	Root canal – Bicuspid (excluding final restoration)	$ 425.00
D3330	Root canal – Molar (excluding final restoration)	$ 519.00

Apexification/Recalcification Procedures		
D3351	Apexification/recalcification – initial	$ 201.00
D3352	Apexification/recalcification – interim	$ 91.00
D3353	Apexification/recalcification – final	$ 139.00
Apicoectomy/Periradicular Services		
D3410	Apicoectomy/Periradicular Surgery – Anterior	$ 349.00
D3421	Apicoectomy – Biscupid (first root)	$ 363.00
D3425	Apicoectomy – Molar (first root)	$ 393.00
D3426	Apicoectomy – each additional root	$ 185.00
D3430	Retrograde filling – per root	$ 136.00
PERIODONTICS		
Surgical Services (Including Usual Post Operative Services)		
D4210	Gingivectomy or gingivoplasty – four or more teeth per quadrant	$ 330.00
D4211	Gingivectomy or gingivoplasty – one to three teeth per quadrant	$ 99.00
Adjunctive Periodontal Services		
D4341	Periodonal scaling and root planing – four or more teeth per quadrant	$ 135.00
PROSTHODONTICS (REMOVABLE)		
Complete Dentures (Including Routine Post-Delivery Care)		
D5110	Complete denture – maxillary	$ 724.00
D5120	Complete denture – mandibular	$ 724.00
Partial Dentures (Including Routine Post-Delivery Care)		
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth	$ 549.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth	$ 554.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$ 800.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth	$ 800.00
Repairs to Complete Dentures		
D5510	Repair broken complete denture base	$ 100.00
D5520	Replace missing or broken teeth – complete denture (each tooth)	$ 85.00
Repairs to Partial Dentures		
D5610	Repair resin denture base	$ 95.00
D5620	Repair cast framework	$ 150.00
D5630	Repair or replace broken clasp	$ 125.00
D5640	Replace broken teeth – per tooth	$ 85.00
D5650	Add tooth to existing partial denture	$ 105.00
D5660	Add clasp to existing partial denture	$ 125.00
Denture Reline Procedures		
D5730	Reline complete maxillary denture (chairside)	$ 175.00
D5731	Reline complete mandibular denture (chairside)	$ 175.00
D5740	Reline partial maxillary denture (chairside)	$ 148.00
D5741	Reline partial mandibular denture (chairside)	$ 148.00
D5750	Reline complete maxillary denture (laboratory)	$ 228.00
D5751	Reline complete mandibular denture (laboratory)	$ 220.00
D5760	Reline partial maxillary denture (laboratory)	$ 213.00

D5761	Reline partial mandibular denture (laboratory)	$ 213.00
ORAL AND MAXILLOFACIAL SURGERY		
Extractions (Includes Local Anesthesia, Suturing if needed, and Routine Postoperative Care)		
D7140	Extraction – erupted tooth or exposed root	$ 68.00
Surgical Extractions (Includes Local Anesthesia, Suturing if needed, and Routine Postoperative Care)		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$ 133.00
D7220	Removal of Impacted tooth – soft tissue	$ 169.00
D7230	Removal of impacted tooth – partially bony	$ 220.00
D7240	Removal of impacted tooth – completely bony	$ 255.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$ 148.00
Other Surgical Procedures		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$ 278.00
D7280	Surgical access of an unerupted tooth	$ 204.00
D7283	Placement of device to facilitate eruption of impacted tooth	$ 37.00
D7285	Biopsy of oral tissue – hard	$ 153.00
D7286	Biopsy of oral tissue – soft	$ 143.00
Alveoloplasty-Surgical Preparation of Ridge for Dentures		
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$ 133.00
D7320	Alveoloplasty not in conjuction with extractions – per quadrant	$ 182.00
Removal of Tumors, Cysts and Neoplasms		
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	$ 266.00
D7471	Removal of lateral exostosis – (maxilla or mandible)	$ 154.00
D7510	Incision & drainage – intraoral	$ 121.00
Other Repair Procedures		
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	$ 208.00
ORTHODONTICS		
Comprehensive Orthodontic Treatment		
D8080	Comprehensive orthodontic treatment – adolescent – banding and records	$ 1,300.00
	Maximum comprehensive case rate of $3,600 including one set of retainers and 12 months adjustments	
Other Orthodontic Services		
D8660	Pre-orthodontic visit	$ 50.00
D8670	Periodic orthodontic treatment visit – maximum of 23 monthly payments	$ 100.00
D8680	Orthodontic retention	$ 350.00
ADJUNCTIVE GENERAL SERVICES		
Unclassified Treatment		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$ 50.00
Anesthesia		
D9220	Deep sedation/general Anesthesia – first 30 minutes	$ 233.00
D9221	Deep sedation/general Anesthesia – each additional 15 minutes	$ 79.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide)	$ 30.00
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$ 197.00
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	$ 71.00

D9248	Non-intravenous conscious sedation	$ 89.00

ATTACHMENT VII

LOBBYING DISCLOSURE

Complete this form to disclose TennCare-related* lobbying relationships entered into or existing in the previous fiscal year. Each lobbying relationship/contract requires a separate form.

State of Tennessee
Bureau of TennCare

1. Type of Relationship: *(e.g., ongoing, one-time)*	2. Stated Purpose of the Relationship:	3. Report Type: a. Initial Filing b. Material Change **For Material Change Only:** Year _____ Quarter _____ Date of last Report _____

4. Name and Address of Reporting Entity:	5. Total Reimbursement Paid to Lobbyist: $
6. Name and Address of Lobbying Registrant: *(If individual, last name, first name, MI)*	**7. Individuals Performing Services:** *(Including address if different from No. 6)*

8. List of Individuals Lobbied:
(Including name, job title, subject matter of lobbying activity(ies) and total value of all gifts/remuneration received)

9. "I hereby affirm that to the best of my knowledge my organization and its sub-contractors remain in compliance with state contractual requirements barring payment to state officials."

Signature: _____

Print Name: _____ Title: _____

Telephone No.: _____ Date: _____

* Disclosure is required if any portion of a lobbying relationship relates to TennCare. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related.

** Attach additional sheets if necessary. Include the name of the Reporting Entity and date on each additional sheet.

INSTRUCTIONS FOR COMPLETION OF LOBBYING DISCLOSURE FORM FOR THE BUREAU OF TENNCARE

This disclosure form shall be filed with TennCare and the TennCare Oversight Committee annually by the reporting entity no later than December 31 of each year, beginning on December 31, 2005; however an ongoing duty exists to amend and update all filings. All TennCare-related lobbying relationships and/or contracts should be disclosed on a separate form. Disclosure is required if any portion of funds received under a contract, grant or other relationship with TennCare was paid to a lobbyist or lobbying entity as defined by Tenn. Code Ann. 3-6-102 and as further defined in E.14 of the Agreement. For those Contractors reliant on TennCare for greater than two-thirds of their total revenue in the previous fiscal year, all lobbying contracts will be presumed to be TennCare-related. This form has been designed consistent with federal regulations, 31 U.S.C. 1352 and 42 CFR 93.100. Refer to the implementing guidance provided by the Federal Office of Management and Budget for additional information.

1. Identify the type of lobbying relationship being disclosed (*e.g. ongoing, one-time).* Use a separate form for each lobbyist contract or relationship.

2. Identify the purpose of the lobbying relationship as quoted in the contractual agreement.

3. Identify the appropriate classification of this disclosure. Any material change to information previously reported should be disclosed in an amended form within five (5) business days.

4. Enter the full name, address, city, state and zip code of the reporting entity.

5. Enter the total reimbursement paid to lobbyist in the previous fiscal year.

6. Enter the full name, job title, address, city, state and zip code of the lobbying registrant engaged by the reporting entity identified in item 4.

7. Enter the full name(s) of the individual(s) performing services and include full address if different from item 6. Enter last name, first name, middle initial (MI), and job title.

8. Enter the full name(s), job title(s) of individuals lobbied, the subject matter of the lobbying activity(ies) and the total value of all gifts/remuneration received. (See Tenn.Code Ann. 3-6-102 and Section E.14 of the Agreement for a definition of relevant lobbying activities)

9. The certifying contractor or vendor Chief Executive Officer shall sign and date the affirmation, print his/her name, title, and telephone number.

ATTACHMENT 6.2

PROPOSAL TRANSMITTAL AND STATEMENT OF CERTIFICATIONS AND ASSURANCES

The Proposer must complete and sign this Technical Proposal Transmittal. It must be signed, in the space below, by an individual empowered to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If said individual is not the Proposer's chief executive, this document shall attach evidence showing the individual's authority to bind the proposing entity.

PROPOSER LEGAL ENTITY NAME: _____

PROPOSER FEDERAL EMPLOYER IDENTIFICATION NUMBER:
(or Social Security Number) _____

The Proposer does hereby affirm and expressly declare confirmation, certification, and assurance of the following:

1) This proposal constitutes a commitment to provide all services as defined in the RFP Attachment 6.1, *Pro Forma* Contract Scope of Services for the total contract period and confirmation that the Proposer shall comply with all of the provisions in this RFP and shall accept all terms and conditions set out in the RFP Attachment 6.1, *Pro Forma* Contract.
2) The information detailed in the proposal submitted herewith in response to the subject RFP is accurate.
3) The proposal submitted herewith in response to the subject RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.
4) The Proposers shall comply with:
    a) the laws of the State of Tennessee;
    b) Title VI of the federal Civil Rights Act of 1964;
    c) Title IX of the federal Education Amendments Act of 1972;
    d) the Equal Employment Opportunity Act and the regulations issued there under by the federal government;
    e) the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;
    f) the condition that the submitted proposal was independently arrived at, without collusion, under penalty of perjury; and,
    g) the condition that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractors, or consultant to the Proposer in connection with the Procurement under this RFP.
5) The Proposer shall comply with all of the provisions in the subject RFP and shall accept all terms and conditions set out in the RFP Attachment 6.1, *Pro Forma* Contract.
6) The Proposer shall provide a performance bond in accordance with the requirements of the RFP.

SIGNATURE & DATE: _____

ATTACHMENT 6.3

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION A	
PROPOSER NAME:	

SECTION A — MANDATORY REQUIREMENTS

The Proposer must address ALL Mandatory Requirements section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). The RFP Coordinator will review all general mandatory requirements, including but not limited to the following:

- **Proposal received on or before the Proposal Deadline.**
- **Technical Proposal copies and Cost Proposal packaged separately.**
- **Technical Proposal contains NO cost data.**
- **Proposer did NOT submit alternate proposals.**
- **Proposer did NOT submit multiple proposals in a different form.**
- **Technical Proposal does NOT contain any restrictions of the rights of the State or other qualification of the proposal.**

The RFP Coordinator will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with pass or fail. For each requirement that is not met, the Proposal Evaluation Team must review the proposal and attach a written determination.

NOTICE: In addition to these requirements, the State will also evaluate compliance with ALL RFP requirements.

Proposal Page # (to be completed by Proposer)	Mandatory Requirement Items	State Use ONLY Pass/Fail
	A.1 Provide the Proposal Transmittal and Statement of Certifications and Assurances (detailed in RFP Attachment 6.2) completed and signed, in the space provided, by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. ***Each Proposer <u>must</u> sign the Proposal Transmittal and Statement of Certifications and Assurances without exception or qualification.***	
	A.2 Provide the following as documentation of financial responsibility and stability. ▪ a current written bank reference, in the form of a standard business letter, indicating that the proposer's business relationship with the financial institution is in positive standing ▪ two current written, positive credit references, in the form of standard business letters, from vendors with which the proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months ▪ a copy of a valid certificate of insurance indicating liability insurance in the amount of at least One Million Dollars ($1,000,000.00).	

Proposal Page # (to be completed by Proposer)	Mandatory Requirement Items	State Use ONLY Pass/Fail
	▪ a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of Five Hundred Thousand Dollars ($500,000.00)	
	A.3 Provide a statement of whether the Proposer or any individual who shall perform work under the contract has a possible conflict of interest (*e.g.,* employment by the State of Tennessee) and, if so, the nature of that conflict. ***Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.***	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION B	
PROPOSER NAME:	
SECTION B — QUALIFICATIONS & EXPERIENCE	
The Proposer must address ALL Qualifications and Experience section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). **A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the proposal's "qualifications and experience" responses.**	
Proposal Page # (to be completed by Proposer)	**Qualifications & Experience Items**
	B.1 Describe the Proposer's form of business (*i.e*., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the name, mailing address, and telephone number of the person the State should contact regarding the proposal.
	B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of the Proposer company within the last ten years, and if so, an explanation providing relevant details.
	B.3 Provide a statement of whether the Proposer or any of the Proposer's employees, agents, independent Contractors, or subcontractors have been convicted of, pled guilty to, or pled *nolo contendere* to any felony, and if so, an explanation providing relevant details.
	B.4 Provide a statement of whether there is any pending litigation against the Proposer; and if such litigation exists, an attached opinion of counsel as to whether the pending litigation will impair the Proposer's performance in a contract under this RFP.
	B.5 Provide a statement of whether, in the last ten years, the Proposer has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors, and if so, an explanation providing relevant details.
	B.6 Provide a statement of whether there are any pending Securities Exchange Commission investigations involving the Proposer, and if such are pending or in progress, an explanation providing relevant details and an attached opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract under this RFP.
	B.7 Provide a brief, descriptive statement indicating the Proposer's credentials to deliver the services sought under this RFP.
	B.8 Briefly describe how long the Proposer has been performing the services required by this RFP and include the number of years in business.
	B.9 Describe the Proposer organization's number of employees, client base, and location of offices.

Proposal Page # (to be completed by Proposer)	Qualifications & Experience Items
	B.10 Provide a narrative description of the proposed project team, its members, and organizational structure.
	B.11 Provide a personnel roster and resumes of key people who shall be assigned by the Proposer to perform duties or services under the contract (include estimated number of hours to be worked on the contract for each person, and the resumes shall detail each individual's title, education, current position with the Proposer, and employment history) as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrating the lines of authority and designate the individual responsible for the completion of each service component and deliverable of the RFP.
	B.12 Provide a statement of whether the Proposer intends to use subcontractors, and if so, the names and mailing addresses of the committed subcontractors and a description of the scope and portions of the work the subcontractors will perform.
	B.13 Provide documentation of Proposer commitment to diversity as represented by its business strategy, business relationships, and workforce — this documentation should detail: ▪ a description of the Proposer's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, persons with a disability and small business enterprises ▪ a listing of the Proposer's current contracts with business enterprises owned by minorities, women, persons with a disability and small business enterprises, including the following information o contract description and total value o Contractor name and ownership characteristics (*i.e.*, ethnicity, sex, disability) o Contractor contact and telephone number ▪ an estimate of the level of participation by business enterprises owned by minorities, women, persons with a disability and small business enterprises in a contract awarded to the Proposer pursuant to this RFP, including the following information: o participation estimate (expressed as a percent of the total contract value that will be dedicated to business with subcontractors and supply Contractors having such ownership characteristics) o descriptions of anticipated contracts o names and ownership characteristics (*i.e.*, ethnicity, sex, disability) of anticipated subcontractors and supply Contractors anticipated ▪ the percent of the Proposer's total current employees by ethnicity, sex, and disability ***Proposers that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as Contractors and sub-Contractors. Proposal evaluations will recognize the positive qualifications and experience of a Proposer that does business with enterprises owned by minorities, women, persons with a disability and small business enterprises and that offers a diverse workforce to meet service needs.***

Proposal Page # (to be completed by Proposer)	Qualifications & Experience Items
	B.14 Provide customer references for similar projects representing both three of the larger accounts currently serviced by the vendor and three completed projects as well as a list, if any, of all current contracts with the State of Tennessee and all those completed within the previous five year period. Each reference must include: ▪ the company name and business address; ▪ the name, title, and telephone number of the company contact knowledgeable about the project work; and ▪ a brief description of the service provided and the period of service. The list of contracts with the State of Tennessee must include: ▪ the contract number; ▪ the contract term; and ▪ the procuring state agency for each reference. ***Each evaluator will generally consider the results of reference inquiries by the State regarding <u>all</u> references provided (both state and non-state). Current or prior contracts with the State are not a prerequisite and are not required for the maximum evaluation score possible, and the existence of such contracts with the State will not automatically result in the addition or deduction of evaluation points.***
(Maximum Section B Score = 30)	
SCORE ***(for <u>all</u> Section B items above, B.1 through B.14)*:**	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION C

PROPOSER NAME:	

SECTION C — TECHNICAL APPROACH

The Proposer must address ALL Technical Approach section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the proposal's response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

0 = little value 1 = poor 2 = fair 3 = satisfactory 4 = good 5 = excellent

The RFP Coordinator will multiply each item score by the assigned weight with the product being the item's raw weighted score for purposes of calculating the section score as detailed at the end of this table.

Proposal Page # (to be completed by Proposer)	Technical Approach Items		State Use ONLY		
			Score	Item Weight	Raw Weighted Score
	C.1	Provide a narrative that illustrates the Proposer's understanding of the State's requirements and project schedule.		**10**	
	C.2	Provide a narrative that illustrates how the Proposer will complete the scope of services, accomplish required objectives, and meet the State's project schedule.		**15**	
	C.3	Provide a narrative that illustrates how the Proposer will manage the project, ensure completion of the scope of services, and accomplish required objectives within the State's project schedule.		**15**	
		Total Raw Weighted Score: *(sum of Raw Weighted Scores above)*			

Total Raw Weighted Score / **maximum possible raw weighted score** *(i.e., 5 x the sum of item weights above)*	**X 40** *(maximum section score)*	**= SCORE:**

ATTACHMENT 6.4

COST PROPOSAL & SCORING GUIDE

NOTICE TO PROPOSER: This Cost Proposal MUST be completed EXACTLY as required.

PROPOSER NAME:	
SIGNATURE & DATE:	

NOTE: The signatory must be an individual or a company officer empowered to contractually bind the Proposer. If the Signatory is not the Proposer company president, this Statement of Certifications and Assurances SHALL attach evidence showing the Signatory's authority to bind the Proposer.

COST PROPOSAL SCHEDULE

The proposed cost, detailed below, shall indicate the proposed price for providing the entire scope of service including all services as defined in the RFP Attachment 6.1, *Pro Forma* Contract Scope of Services for the total contract period. The proposed cost and the submitted technical proposal associated with this cost shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any resulting contract between the Proposer and the State. All monetary amounts are United States currency.

Cost Item Description *Actual Payment for Services Provided to Begin January 1, 2006*	**Proposed Cost**		**State Use ONLY**		
	October 1, 2005 – September 30, 2008 Per Member Per Month Rate	**Renewal Period October 1, 2008 – September 30, 2010 Per Member Per Month Rate**	**Sum**	**Weight**	**Weighted Cost**
Administrative Fee Per Member Per Month for each Child (Under Age 21) Eligible for Full Dental Benefit Package				**30**	

The RFP Coordinator shall use the evaluation cost amount derived from the proposed cost amounts above and the following formula to calculate the COST PROPOSAL SCORE. Calculations shall result in numbers rounded to two decimal places.

Evaluation Cost Amount: *(sum of all weighted cost amounts above)*

$$\frac{\textbf{Lowest Evaluation Cost Amount from all Proposals}}{\textbf{Evaluation Cost Amount Being Evaluated}} \times \textbf{30 } \textit{(maximum section score)} = \textbf{SCORE:}$$

ATTACHMENT 6.5

PROPOSAL SCORE SUMMARY MATRIX

RFP Coordinator **Date**

QUALIFICATIONS & EXPERIENCE **Maximum Points: 30**	**PROPOSER NAME**		**PROPOSER NAME**		**PROPOSER NAME**	
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE SCORE:		**AVERAGE SCORE:**		**AVERAGE SCORE:**	
TECHNICAL APPROACH **Maximum Points: 40**						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
EVALUATOR NAME						
REPEAT AS NECESSARY						
	AVERAGE SCORE:		**AVERAGE SCORE:**		**AVERAGE SCORE:**	
COST PROPOSAL **Maximum Points: 30**	**SCORE:**		**SCORE:**		**SCORE:**	
PROPOSAL SCORE **Maximum Points: 100**	**TOTAL SCORE:**		**TOTAL SCORE:**		**TOTAL SCORE:**	

ATTACHMENT 6.6

PERFORMANCE BOND

The Surety Company issuing bond shall be licensed to transact business in the State of Tennessee by the Tennessee Department of Commerce and Insurance. Bonds shall be certified and current Power-of-Attorney for the Surety's Attorney-in-Fact attached.

KNOW ALL BY THESE PRESENTS:

That we,

(Name of Principal)

(Address of Principal)

as Principal, hereinafter called the Principal, and

(Name of Surety)

(Address of Surety)

as Surety, hereinafter call the Surety, do hereby acknowledge ourselves indebted and securely bound and held unto the State of Tennessee as Obligee, hereinafter called the Obligee, and in the penal sum of

Two Million Dollars ($2,000,000.00)

good and lawful money of the United States of America, for the use and benefit of those entitled thereto, for the payment of which, well and truly to be made, we bind ourselves, our heirs, our administrators, executors, successors, and assigns, jointly and severally, firmly by these presents.

BUT THE CONDITION OF THE FOREGOING OBLIGATION OR BOND IS THIS:

WHEREAS, the Obligee has engaged the Principal for a sum not to exceed

(Contract Maximum Liability)

to complete Work detailed in the Scope of Services detailed in the State of Tennessee Request for Proposals bearing the RFP Number:

318.65-208

a copy of which said Request for Proposals and the resulting Contract are by reference hereby made a part hereof, as fully and to the same extent as if copied at length herein.

NOW, THEREFORE, if the Principal shall fully and faithfully perform all undertakings and obligations under the

Contract hereinbefore referred to and shall fully indemnify and hold harmless the Obligee from all costs and damage whatsoever which it may suffer by reason of any failure on the part of the Principal to do so, and shall fully reimburse and repay the Obligee any and all outlay and expense which it may incur in making good any such default, and shall fully pay for all of the labor, material, and Work used by the Principal and any immediate or remote sub-Contractor or furnisher of material under the Principal in the performance of said Contract, in lawful money of the United States of America, as the same shall become due, then this obligation or bond shall be null and void, otherwise to remain in full force and effect.

AND for value received, it is hereby stipulated and agreed that no change, extension of time, alteration, or addition to the terms of the Contract or the Work to be performed there under or the specifications accompanying the same shall in any wise affect the obligation under this bond, and notice is hereby waived of any such change, extension of time, alteration, or addition to the terms of the Contract or the Work or the specifications.

IN WITNESS WHEREOF the Principal has hereunto affixed its signature and Surety has hereunto caused to be affixed its corporate signature and seal, by its duly authorized officers, on this

_____ day of _____ , _____ .

WITNESS:

_____	_____
(Name of Principal)	(Name of Surety)
_____	_____
(Authorized Signature of Principal)	(Signature of Attorney-in-Fact)
_____	_____
(Name of Signatory)	(Name of Attorney-in-Fact)
_____	_____
(Title of Signatory)	(Tennessee License Number of Surety)